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Homemakers as a School Service

Abused Parents of Abused Children

Group Learning for Foster Parents

Louisiana Family Planning Project

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Schoolmates with a common interest reflect the pleasure of an easy friendship in their smiles. In schools where real integration of the races has long been an accepted practice, color consciousness among young pupils is dim. How vivid it has been in some newly desegregating schools and the ways children have coped with it have been poignantly described by Dr. Robert Coles in a book discussed on pages 197–199.

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In Highland Park (Michigan), the public school system has found that the provision of a teaching homemaker service within the school system to help improve conditions in the homes of socially maladjusted pupils has made a big difference in the way such children take advantage of the schools' social and educational opportunities.

For years, the system tried without notable success to cope with the problems of socially maladjusted children in its elementary schools through psychological services, special material in its curriculum, and the use of community agencies such as a child adjustment clinic and a neighborhood service organization. The behavior of maladjusted children, often characterized by aggressive acting-out toward other children and complete lack of respect for adults, was often so great that the children got little or nothing from attending regular classes and so unacceptable that they were excluded from regular classes and sent to special classes. Unfortunately, their parents usually interpreted exclusion as meaning rejection and were unwilling to work with the school in providing treatment for the family. In these instances, the school attempted part-time schooling or referral to the court or to a community treatment agency.

To meet these problems, in 1964 the school system turned over the Lincoln Avenue School to a Pupil Adjustment Project to which all children in elementary school having problems of social adjustment were assigned. The 3-year project, supported by a grant from the Office of Education, U.S. Department of Health, Education, and Welfare, set out to demonstrate that a public school system can provide the psychoeducational services necessary to treat or prevent social maladjustment in children.

Highland Park, a politically independent unit enclosed by the city of Detroit, faces the same problems most inner cities of large urban areas are now facing: it is in social transition and is inhabited by people of several racial, religious, and national backgrounds. For these reasons, it presents conditions that make it nearly ideal as a laboratory in which to examine social and educational problems and to test and demonstrate solutions to them.

Correction and prevention

The project has a two-pronged goal: through *remedial work*, to help the children assigned to the school learn to use educational opportunities effectively; and, through *preventive measures*, to modify

the TEACHING HOMEMAKER in a school project

MARY E. BURNS • JULIA ANN GOODMAN

patterns of family life that encourage the development of social maladjustment in children.

To achieve this goal, the project drew up a three-part plan. The first part called for a school program using special educational methods, small classes, and individual attention to help the children learn how to benefit from the school socially and educationally. The second part called for social casework and groupwork services for all children at Lincoln and for their families to effect positive relations between the child and the school, the family and the school, and the child as a member of a schoolclass and other children in the class. The third part called for the entire staff of the project, both educational and clinical, to involve all parents, both mothers and fathers, in social and educational activities in the school. These activities were to include special meetings between parents and staff members; parent-teacher conferences in place of report cards; and involving parents, usually in groups, in planning for school activities such as picnics, camping trips, holiday dinner parties, and field trips.

The third part of the plan also included setting up a teaching homemaker service to offer individual parents and parents in groups a program aimed at helping them make their homes adequate and orderly, qualities missing in most of the homes of children assigned to Lincoln, through instruction on homemaking in the home. Lincoln's staff believed that orderly homes would provide children with the kind of orderly model of the world they needed to bring more order into their behavior. The use of a homemaker to instruct a family in homemaking rather than as a mother's helper or substitute was an unusual feature of the project.

The school's homemaking service began in September 1965. Lincoln Avenue School had 83 children from 26 families. Six families were not intact; one mother was dead, five fathers were absent. Four families had acute housing problems; 14 families had insufficient income; 13 families had acute health problems. Both parents worked in 10 families.

The project's staff included three social caseworkers. In addition, a professor of social work at a nearby university served as a permanent consultant to the clinical staff. To recruit homemakers for the program, the school contacted nearby agencies such as the United Community Services of Metropolitan Detroit, which was itself setting up a homemaker service in Detroit; the Merrill-Palmer School, where candidates for the new Detroit homemaker agency were being trained; the local office of the U.S. Employment Service; and local Highland Park agencies, including the department of home economics of Highland Park High School and the local visiting nurse association.

In September 1965, two young women were engaged as teaching homemakers. Both had been married over 10 years and each had two children. One, a native of Detroit, had been a case aide for the Detroit Department of Welfare before moving to Highland Park. The other, from West Virginia, is a home economist. Both had worked for the Co-operative Nursery School Program run by the Highland Park public school system.

At the onset of the program, the staff received help from a consultant, the director of a homemaker service in Washington, D.C., in preparing statements of purpose and policy and in designing the program's structure. At this time the role of the home-

maker was defined as that of a "teaching homemaker" who uses a variety of educational methods. The chief social worker was made responsible for supervising the homemakers and for assigning the cases. The homemakers worked as integral members of an interprofessional team of caseworkers, psychologists, and teachers and their services were a key adjunct to the casework process. The caseworker assigned to the family was responsible for direct work with the family.

Knowing that the homemakers and caseworkers were part of a team calling for unusual relationships and that there were few guidelines to insure effective interaction among team members, the staff met weekly to discuss these aspects of the service:

1. Clarification of the distinct and the overlapping areas of the work of homemakers and caseworkers.

2. Development of ways in which homemakers and caseworkers can work together effectively to carry out casework plans for particular families.

3. Ways to break down socioeconomic and cultural and lay and professional bias that might be reflected in the work of the caseworkers and homemakers.

4. The need for the homemakers to be accepting, flexible, and adaptable and to use imagination and sensitiveness in helping families with their problems.

Kinds of tasks

In reporting on their first days, the teaching homemakers made these comments:

When we were asked to be teaching homemakers, a number of questions came to our minds. What would we wear? Would we be accepted? If not, how could we sell ourselves to our clients? What kinds of problems would we encounter? What should our goals be? We defined our goals as "to gain the confidence of the parent, to help, to teach, and to create an interest in upgrading family life." (An easy task—on paper!)

* * *

It took many weeks of preparation before going into the homes. We read case histories to familiarize ourselves with identifying family data and existing problems and to try to decide what services would be needed. We gathered material on household hints, child care, meal planning, marketing, budgeting, proper cleaning techniques, and recipes which would fit limited food budgets and meet the nutritional requirement of the family.

After 18 months of experience in the use of the educational homemaker program, the staff of Lincoln can now place the activities of the teaching homemaker's job under these three categories:

1. Teaching good methods of home management, child care, and personal care to families individually. Here, the teaching homemaker's task as part of the team is to help set up and maintain equilibrium in the family. (For example, a homemaker helped a mother draw up a budget for her food money.)

2. Helping individual families use medical and health resources to correct and prevent severe family problems and the related problems of children. (For example, in a home where the mother had a severe skin disorder and the children had it intermittently, the teaching homemaker got the mother to take steps to prevent the spread of the infection.)

3. Setting up broad group educational programs that allow the homemaker to use her talents and creativity. (For example, the teaching homemakers introduced a program for small groups of mothers to show them how to plan meals, mend clothing, and refinish furniture.)

The teaching homemakers worked a 7-hour day for 5 days a week. Usually each homemaker was in two homes a day for 3 hours each. The other hour was taken up with travel and writing brief reports of activity, including an evaluation of the service and how the homemaker was received in the home. To confine the homemaker as much as possible to teaching, the policy was not to allow the homemaker to stay in any home for a full 7 hours, except in an emergency. Because some families attempted to use the homemaker as "domestic help," the two homemakers visited the same home alternately.

After their first visits to several homes, the homemakers found they needed many supplies. They reported:

. . . we realized we needed our own cleaning supplies and equipment. Not only was there lack of money in the home for this kind of equipment, but also a lack of knowledge of supplies needed. For our own protection, antiseptic soap headed the list. Many of the homes had no workable laundry equipment; washing machines were either absent or broken; irons, outdated or broken. We found we needed two sewing machines, a console to be used in the school and a portable to take to homes.

Thereafter, they carried necessary cleaning supplies and equipment in their automobiles to and from each home. Equipment was never left in a home.

The homemakers never gave money. If a family was without food or other essentials, they reported the need to the caseworker assigned to the family.

The teaching homemakers wore distinctive uniforms of blue-and-white striped cambric pinafores

decorated with an emblem reading "Teaching Homemakers Lincoln Avenue School." They also wore long-sleeved navy blue coat sweaters when working in unheated homes.

The first home

No words can tell better than the homemakers' own what the first home they visited was like and the problems it presented:

Going into our first home (a family of six children, mother, and father) and seeing the conditions of the home and the number of problems, we wondered if we had accepted jobs too complicated for our abilities. This home was roach infested. There were mounds of mildewed clothes piled in the basement. The two younger children in the home were hungry and naked; they were both ill with diarrhea. The mother suffered from a severe skin disorder and could not put her hands in water. The house was in complete disorder. In addition to the clothes in the basement, soiled and clean clothes mixed together were piled on the living room sofa, chairs, and floors. Bread, jelly, peanut butter, and dry cereal were strewn on the floor from the front door to the back door.

This family was in a state of nearly complete disorganization. In addition to chaotic conditions in the house, the personal relations between mother and father and between parents and children were both aggressively and passively hostile. The mother never talked to the children except to swear at them and to call them obscene names. She, more than the father, disciplined the children severely. The parents met neither the emotional nor the basic physical needs of the children. Health problems were rampant, but no medical care was ever sought. The father provided income, but no other physical or emotional help for the family. He and the mother had a severe marital problem, and he was absent from the home more than he was present. The mother was almost completely immobilized by her physical and emotional problems.

The children of the family who were referred to our school were markedly withdrawn, could hardly speak except in obscene expletives, and were failing in their schoolwork. Psychological testing at the time of the referral indicated that they had potentially average intelligence but that their ability to function was impaired. Psychiatric evaluation indicated that they were suffering from severe emotional, as well as physical, deprivation and that they were distrustful and fearful of interpersonal relationships and had potential for marked aggressive behavior.

To meet this family's needs required all of our school's services: intensive casework; groupwork; homemaker services; and special educational programs, including, in addition to special classes, special educational diagnoses and tutoring from our reading specialist. In addition, through our casework service, we called on other community services such as the public health nurse and visiting nurse services, a dermatological clinic, and an adult psychiatric clinic for help. Through our own pediatric service, each child received a complete physical examination.

When the homemaker first entered the home, the mother could not think of what help the homemaker could be. Finally, she asked the homemaker to throw out an open jar of peanut butter, covered with roaches, which had been on the table for weeks. From this beginning, the homemaker moved step by step with the mother to do the laundry and clean the house.

Each week the homemaker gave the mother a little more responsibility for doing tasks in preparation for the homemaker's visit: The first week she was only asked to gather the soiled clothes in one place; but in the weeks following she was asked to also sort them by color and by kind, to run water in the machine, and to put the clothes in without getting her hands wet. Finally, with encouragement, the mother could handle the laundry herself. The husband was induced to mend and put up a line that had been down for several years on which the clothes could be hung to dry.

Casework with the parents was directed at modifying the hostility toward the children; changing the pattern and forms of discipline; and supporting the parents' continually improving ability to act as parents, through the mother's pregnancy and the birth of a seventh child. Homemaker and caseworker often got in touch with each other to share information and diagnostic understanding and to discuss immediate and long-range goals for treatment. They carefully coordinated treatment plans and activities.

After many months of receiving intensive casework service during which both teaching homemakers worked with the family, this family showed marked improvement in many ways—the marital relation-

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ship, child care, home management, and physical and emotional health of the parents and children. The parents even joined in group activities at the school.

The positive influence of this method of working with the whole family was reflected in the children's behavior. They became more spontaneous, talkative, and comfortable with other people. And they began to respond well to remedial education.

The parents' change in attitude toward the school and their acceptance of the school program brought about another important gain. Their positive attitude, which they transferred to their children, greatly increased the children's ability to do good school work.

Problems with other families ranged from simple to complex, from the need of a mother to learn how to prepare appealing and nutritional meals to a father's need for help in finding a housekeeper for his motherless family. In some families the homemakers together gave as many as 156 hours of service; in others, only 8 or 10 were required. Many families continue to need teaching or supportive services.

As the homemakers became more familiar with the families, they found that similar problems existed in several of them. In the belief that the mothers in these families would respond to the group method of treatment, they planned activities for the mothers that resulted in weekly meetings to consider many aspects of homemaking. The homemakers found the group meetings had good results in many cases.

The value of groupwork was particularly noticeable in one family. The mother had received many hours of teaching homemaker service in her home but showed little evidence of changing until she attended a group meeting on refinishing furniture. Through her interest in the work, she changed her run-down house to a bright and pleasant home. In turn, her husband, responding to the change inside the house, repaired and painted the outside.

Part of casework

In reviewing the work of the teaching homemakers, the members of the team see the service as a part of casework service. It is oriented to change; it has specific goals within the caseworkers' goals; and its methods are on-the-spot teaching about and demonstration of effective home- and child-care practices. The effective use of such a service presupposes that these requirements are being met:

1. A diagnostic evaluation of the family and of the role of each member, including an evaluation of each member's motivation and capacity for improving and a clinical judgment that the parents are not providing adequate homemaking and child care.

2. Based on this evaluation and judgment, a selection of what further services are needed and available.

3. A continuing evaluation of family need and changes in goals and services as required.

Responsibility for diagnosing the family's problems and for deciding whether to use the homemaker as a teacher rested with the caseworker, as set forth in the casework plan. As teachers, the homemakers showed the contribution this kind of service could make to help the Pupil Adjustment Project attain its goals. The nature of the problems presented by the families required the homemakers to assist families in ways besides teaching. In addition to working with parents directly, they had to help make plans for medical care, care for children when a mother could not, stabilize families in a crisis, and relieve overburdened mothers.

As we see it, the success of the teaching homemaker program depended on the following factors:

1. From the homemaker, acceptance of the parent to be taught; conviction that parents want to be good parents; skill in working together with parents (doing *with* rather than *for*); ability to demonstrate good homemaking and child-care methods directly and indirectly; and ability to recognize the parents' attainment and to praise them for it.

2. The kind of team relationship that prevents the development of rivalry or dissension between caseworkers and homemakers from overlapping responsibilities.

3. Careful selection of the teaching homemakers.

4. Conviction on the part of the entire staff that a teaching homemaker service is worthwhile.

Under these conditions, teaching homemakers provide a treatment resource that can be useful in many instances. They have certainly helped many of the children of Lincoln Avenue School and their parents. The demonstration at Lincoln School of what such a service can do has prompted the Highland Park public school system to provide a homemaker program for its entire school district under a special grant from the State.

understanding
comes first
in helping . . . . . .

the ABUSED parent of the ABUSED child

SIDNEY WASSERMAN

Willful intent in parents to injure their own children is an "unthinkable thought" for most of us. Even physicians, persons who seem to be in a position to judge whether violence has been done to a child, are often unwilling to accept the "reality of willful child abuse," according to a recent survey among physicians in the Washington metropolitan area conducted by a group of psychiatrists.[1] A fifth of the nearly 200 physicians questioned said they rarely or never considered the "battered child syndrome" when seeing an injured child, and a fourth said they would not report a suspected case even if protected by law against legal action by the parents. Apparently, they did not believe the evidence would stand up in court.

To accept as fact that some parents intentionally injure their children is difficult and upsetting. Thus, we all tend, like the physicians studied, to give the parent "the benefit of the doubt." There may be many reasons for our reluctance, but one is certainly this—when we accept willful intent as a fact, we must face our anger at such parents and our desire to protect the child, even if we harm the parent. But we cannot effectively intervene to protect an abused child and prevent abuse from recurring unless we understand what it is like to be a "battering parent."

One of the dangers of using the label "battering parent" is the possibility of increasing bias and prejudice against the parent. Labeling a particular person as a "battering parent" can release us from the responsibility of making our response to and attitude toward his actions sensitive to his needs. The temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous.

How easy it is to deny that within all of us lies a potential for violence and that any of us could be unreachable! What is more repugnant to our rational, "mature" minds than the thought of committing impulsive, violent acts against a helpless child? We tell ourselves that the primitive, untempered instincts responsible for such acts could not erupt in us. But stripped of our defenses against such instincts and placed in a social and psychological climate conducive to violent behavior, any of us could do the "unthinkable." This thought should humble us: perhaps we are not battering parents only because conditions do not lead us to commit "unnatural" acts.

No class monopoly

Writers on social phenomenon, lawyers, social scientists, and others interested in social problems have long recognized that the phenomenon of parents physically abusing their children has been with us since the beginnings of mankind. Only since World War II, however, has much been written on the subject of unexplained, shocking, and traumatic injuries to children. Since then, too, much has been said and written about the legal confusion surrounding the use of authority and sanctions in instances of apparent abuse of children by their parents.

Historically, the helping professions have viewed physical abuse of children by their parents as the result of poverty, life in the slums, ignorance, and the hardships produced by immigration, war, industrialization, and urbanization. No one can deny that these conditions can be a cause of child abuse. Nevertheless, we are finding that the phenomenon can be found anywhere in society. Once we regarded violence against a child as characteristic of parents in the lower socioeconomic classes. Now we are finding that such behavior is not exclusive with any particular social class but that "better" families can more easily conceal the problem than poor ones. In other words, a sociological explanation by itself is inadequate and simplistic.

Through sometimes frustrating and bitter experience, the professions, and particularly that of social work, have come to see that prosecuting the battering parent solves the problems of neither the child nor the parent. Helping the abused child leads us inevitably to the need to help the battering parent and family. As pointed out by Delsordo,[2] Boardman,[3] Nurse,[4] and others in studies of child abuse, practically all cases of abuse involve longstanding, severe interpersonal conflict either between the parents themselves or between one parent and another member of the family.

Because we are dealing with a complex subject involving many social, psychological, medical, and legal elements, we must narrow our scope and take first things first. Nothing precedes understanding who the battering parent is and what he is. Studies point out that battering parents and families, regardless of class, have certain psychological and social characteristics in common; for example, we are learning more all the time about the severe damage to personality these people suffer. Few are psychotic, but all have marked inability to set up a genuine relationship with another human being. Absorbed by their own hurt feelings, they cannot sympathize with the feelings of others. The nonpsychotic battering parent seldom shows remorse for having hurt his child, but he can be very much concerned about the harm a person in authority might inflict on his own person. When facing a person in authority, he cries out: "What are you going to do to me?"

"Done to"

Obviously, something went haywire or was not touched in the humanization process when such persons were growing up. Apparently, they never had the kind of relations with other people that offers incentives for delaying pleasure or gratification or the feeling that it is worthwhile to yield an immediate, antisocial pleasure for the love and acceptance of another. They have been "done to" both socially and psychologically. A battering adult goes about his daily life with the gnawing, unfulfilled feeling of having been unloved or not having been loved as much as he should have been as a child. His life is focused on his own needs, and he cannot tolerate any frustration to the gratification of those needs. What else can he feel but his own hurt, his own hunger for love? He is anesthetized against feeling compassion for others.

This kind of person, according to Reiner and Kaufman,[5] is unaware that he has a buried feeling of "imbedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act he interpreted as rejection of himself. Unable to understand such a distressing emotional event and not psychologically strong enough to bear it, as a child he buried the feeling of rejection deep within himself and with it the accompanying depression. Because his use of language was not developed, he expressed his feelings by the only means he had—his behavior. Explosive, violent behavior became his means of communicating with those around him. When he was violent, he was unable to feel his hurt, his sense of worthlessness, his depression. Denied a consistent, supportive relationship with an adult, he set up a life pattern of aggression and violence—and is now inflicting on others what was inflicted on him. For him the world is hostile and dangerous; it is a place where one attacks or is attacked.

Studies also suggest that the battering parent feels his parents were punishing him when they rejected him and that he is longing for a mother. He wants to be loved, yet does everything to prevent another from loving him. Instead, he is caught in a cycle of violence and rejection. When speaking of his physical attacks on his child, the battering parent strongly

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defends his right to act as he has. He seems unable to feel love for and protectiveness toward his child. He can be extremely compulsive in his behavior and make unreasonable demands on his child. Cleanliness, for instance, may be an obsession with some. I have heard of a child being mercilessly beaten for putting chicken bones on a clean tablecloth and of an 18-month-old baby being seated with his buttocks uncovered on a hotplate whenever he soiled himself. Such people are way over their heads when they become parents. How can they give a child what they have never had themselves—security, safety, and love?

The hostility sponge

This description is supported by a growing amount of evidence that when a battering parent becomes violent, he apparently is releasing his rage on a particular child, selected to act as the "hostility sponge" for that rage. The parent views the child as a competitor, as someone taking and getting what belongs to him. The child is an unconscious symbol of someone or something that once caused him pain—a competitive brother or sister, a distrusted parent, his rejected self. Sometimes the parent is reliving a childhood experience that left him traumatized. Some of these parents talk about being rejected by their own parents in favor of a brother or sister.

In many instances the abused child has been conceived out of wedlock. The parent is now punishing him for being the cause of an unwanted marriage. Sometimes a stepfather is the offender. He beats the child for reminding him of his wife's "badness." Or the mother may beat the child because he reminds her of her "badness" or of that "bad" man, his father, who deserted her when she was pregnant. By beating out the "badness" in the child, the parent beats out his own badness or that of another person who has injured him. In other words, the parent is reacting to his own inner feelings, not to the behavior of the child. The child is the provoker by being what he is—an infant or a child demanding attention. It is this demand that provokes the parent.

The use of the child as a hostility sponge may be absolutely essential to the mental balance of the parent, and, thus, the child is sacrificed to that mental balance. Removing the child from the home without a well thought-out plan to help the parent and the family may only invite the parent to shift his rage to another child. We can easily get caught up in symptom-shifting without getting to the bottom of the problem—the parent's need to be protected from himself.

To really help such a parent, we must break the chains he has inherited. To do that, we must clearly understand that intervention should act as a brake on the parent's behavior and that the injuries he inflicts on the child, injuries that bring the attention of the community to join them, are his way of saying—"Stop me!" The act of rushing a child to a hospital or of beating him in front of neighbors or strangers carries a message to the community—"Please save me from going out of control. Stop me from going out of my mind. Keep me from—killing!"

We are gradually realizing that in such cases we are dealing not only with a seriously disturbed person but also with a disturbed family. Once the existence of abuse is ascertained and the degree of imminent danger determined, the parent and the family must be dealt with whether or not the child is removed from the home. Even in cases where law enforcement has been effective and community services have been well coordinated, problems in helping the battering parent and the family remain.

According to Zalba,[6] battering parents tend to deny their actions, the husband or wife of the battering parent protects the other, or the children are too young to explain to outsiders what has occurred in the home. The parents also tend to deny the existence of personal or family problems and to provoke judges, lawyers, and social workers by making impossible demands on them; or they rage at everyone in authority and, sometimes, physically attack them.

Firmness above all

In reaching out to the battering parent, we must keep in mind an important key to his behavior—his fear of a close relationship. Because he suffered rejection in early life, he wards off human relationships.[5] He has emotionally divorced himself from the significant people in his life. He feels safer with and responds more readily to a relationship that clearly offers authority—firm but not punitive. In other words, the battering parent can often be reached by setting firm limits and controls on his behavior. Whatever he may say, he needs firm control—and wants it. In the early stages of trying to reach the battering parent and family, the social caseworker or other helper must make realistic judgments and decisions for and with the parents and family to gradually help them develop a sense of reality.

To provide this basic treatment requires long-term help from a consistent relationship with one person only. Shifting the parent from one worker to another only stirs up his basic, deep-seated belief that to get close to another human being is to expose one's self to hurt and abandonment. Deep within, he sees himself as the kiss of death in personal relations. He wants to get close to another person, but he thinks that if he does the person will learn to dislike him and will break off the relationship. For a long, indefinite period, the helping person must stand by and support the parent by setting limits and by providing services through community resources. He must not try to get too close to or expect such a person to unload his innermost feelings, especially feelings he is hardly aware of. For such a person, having limits set on explosive, violent behavior provides the kind of protection a good parent would give. The battering parent must be constantly assured that he will not be allowed to get out of control. At the same time, he must be assured that the worker believes that he does not want to hurt his child, that he is capable of change, and that he wants to be a better parent. He needs to learn what the community expects of him and what choices he has. He needs to be helped to understand clearly that consequences will follow his violent act and what those consequences will be.

A long process

In this long and trying process, such a parent will continually test the patience of the helping person and will use every means to provoke rejection to reassure himself that he will not be rejected. For a long time he will reveal only his unlikeable side. When he is reassured, he will make feeble attempts to plant the seeds of a relationship. Reaching out to such a person makes a very great emotional and intellectual demand on the helping person. The battering parent is very perceptive and can immediately sense insincerity. Actually, the helping person must become the "hostility sponge" instead of the child by letting the parent test him, yet he must never let the parent get out of control.

Psychiatrists, psychologists, social caseworkers, and other persons trained for this work have observed that as treatment progresses and a basic trust is established the battering parent gradually faces up to the depression within himself. With extreme caution, he talks about his deep-seated fear that he is a loser and that people always desert him. Only when his need for violence abandons him and he stops expressing himself through it can he talk about his childhood and begin to come to grips with his problems. Though he improves, he continues to try to provoke the helping person, for he is never convinced that he will not be rejected. However, he does move cautiously toward having a relationship with the helping person, gives up or modifies his violent outbursts, and lets himself be guided toward patterning his actions after the standards of the helping person. In time, the pattern becomes a part of him and a new self appears.

To start and set in motion such a long, painstaking process requires a firm commitment by the community to providing excellent service, a goal not easily attained. To obtain qualified staff members and to train persons specifically as workers are expensive and time-consuming. Often efforts to reach the battering parent are obstructed because workers—nurses, social workers, volunteers—come and go frequently on the staffs of agencies. For the battering parent is likely to regard a change in workers as another experience in rejection. The helping person may leave the staff at the most critical moment—just as the parent is testing the worker to find out if rejection will follow his actions. The parent takes the worker's leaving the agency as proof that it never pays to get close to another person. If only a community or agency could insure permanent service for such troubled human beings!

But life affords few opportunities for permanency. We are all only temporary to each other. That is a human condition, and most people accept it. The battering parent cannot. Plans for helping him must include ways to help him accept this truth. We must be ready to test various methods of working with him, always keeping in mind his deep fear of involvement and loss. We must continue to direct efforts to alert the medical, legal, and social work professions, and all groups who might come in contact with the battering person to the need for continuity in helping him. The challenge is not a small one; social workers are finding that cases involving battering parents as well as other hard-to-reach families are making up more and more of their caseloads.

In addition to individual treatment, working with groups of battering parents and their spouses is also proving effective. Many of these parents are isolated from the community. Having an opportunity to socialize in a group of similarly troubled parents tends to lower their resistance to facing and discuss-

ing their problems.[6] Working with such families as family groups has also proved effective.[6]

The community must learn

Beyond the abused child, his parents, and his family is the community around them. Battering parents and their families suffer from a not uncommon malaise often called "community exclusion." In various ways, whether economically, politically, psychologically, or socially, these families frequently suffer exclusion. Unfortunately, when such persons vent their rage on their children and the shocked community retaliates immediately, the family's sense of rejection is increased. A cycle of reciprocal aggression is set in motion and, once set in motion, is difficult to halt. The battering parent often succeeds in provoking hospitals, the police, the courts, and social agencies into treating him as his parents once treated him—the opposite of what he needs. Communities must constantly reexamine ways to set up controls and limits while bringing all families into the community life. When a battering parent has only known "community exclusion," he desperately needs "inclusion" to break the cycle.

Finally, we cannot examine our attitude as a community toward the battering parent without examining what it means to be part of a whole—a State, a nation, or the world. Like it or not, we are bound each to the other and our destinies are interwoven. As we try to understand the battering parent, we must look into ourselves to find out what there is in each of us, in our community, our Nation, and the world that the battering parent takes as a sign that what he is doing is permissible.

To answer this question we must face up to the paradoxes in our moral code that condemn violence in one form, permit it in another. Many Americans seem to persistently dismiss from their thoughts and acts a basic truth—there is nothing more precious than human life, or so it seems to me.

The people of the United States have yet to learn how to convert their tendency to violence into compassion and tenderness. We are in danger of losing sight of one of this Nation's major social goals, one on which it was founded, that is, to tap the humanity and creative potential of all citizens and to provide the environment and resources necessary for the individual citizen to realize his creative potential. We possess the potential both for violence and for humaneness, and are capable of acting in brotherhood and with understanding. If this were not so, we would not now be seeking new and different ways of helping our less fortunate citizens. By seeking to tap the humanity and potential for growth of the battering parent and family, we are tapping our own potential for personal, community, national, and international growth. We must ever encourage the tapping of this potential.

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The hardest work in the world is being out of work. There is nothing more difficult or tragic than for a father to return home night after night after an unsuccessful day hunting for a job—a job requiring skills which he does not possess. There is nothing harder than sending one's children to school on an empty stomach. There is nothing harder than living in a slum, than fighting the rats, than pleading with the landlord for heat, than freezing in winter, or than sweltering in summer.

Whitney M. Young, Jr., Executive Director, National Urban League, to the 1965 forum of the National Conference on Social Welfare.

GROUP LEARNING FOR FOSTER PARENTS

I. IN A VOLUNTARY AGENCY

HARRIET GOLDSTEIN

Over the past 7 years the foster parents who care for children placed with them by the Association for Jewish Children, a voluntary agency in Philadelphia, have helped the agency develop a broad program of group activities designed to improve their competence as foster parents and enhance their status within the agency. The program has not only contributed to the foster parents' confidence in their ability to cope with the children in their care but also to the professional workers' understanding of the problems and feelings of foster parents and, hence, their skill in working with them.

At any one time, the agency has about 100 children—most of them severely emotionally disturbed—in the care of 70 to 75 couples whose homes have been approved for foster care.

While the agency had long operated on the principle that work with foster parents requires the use of both casework and groupwork methods, until 1960 its efforts to work with foster parents in groups were sporadic and brief. By the end of 1959, its group program for foster parents had been reduced to two events: an annual meeting for them at the agency and an annual party given in their honor by the board of directors. However, because of its previous experience and the many expressions of interest from foster parents in having opportunities to come together more often, the agency never lost its conviction that a broader, more dynamic group program for foster parents was desirable.

Early in 1960 the agency took steps to get the foster parents' own ideas on the subject. It submitted a questionnaire to all its foster parents, seeking their frank opinion about (1) whether they wanted a group activities program; (2) whether they would be willing to help the agency develop a new program; (3) what suggestions they had for its form and content; and (4) what they thought were the reasons why the former group programs had not been sustained.

Eighty percent of the foster parents responded to the questionnaire, most of them indicating a strong interest in participating in an expanded group program.

Getting under way

The agency was determined not to produce another short-lived group program. It, therefore, re-examined its previous experience with group programs in the light of the foster parents' responses to the questionnaire and identified 10 major points that would have to be kept in focus in developing and operating an expanded group program.

These points were:

1. Staff members have to be available to the foster parent groups on a sustained basis.

2. The staff members have to be flexible enough about their working time to participate in evening meetings or Sunday events.

3. Agency suggestions about programing cannot be imposed on the foster parents but can only be introduced as the foster parents are ready for them.

4. Out of respect for their "quasi-professional" status, the foster parents must be encouraged to assume responsibility for planning and handling their meetings.

5. To function adequately as "quasi-professional" persons, the foster parents need to have a complete picture of the agency's operations and some knowledge of the other child welfare programs in the community.

6. Because foster-parenting is a specialty for which formal training has not been developed, one goal of a group program must be to teach the participants how to fulfill better their role as foster parents.

7. Participation in a group program can help foster parents who have few opportunities for socialization compensate for this deficiency by giving them a closer identification with the agency and the broader community of child welfare services than they had when they became foster parents.

8. Through participating in programs with other couples who are caring for foster children, foster parents—who often feel isolated in their work with children—can come to see the problems of foster children and their natural parents in a broader perspective.

9. All foster parents cannot be expected to participate in the group activities, but in order not to cause confusion for those who do, communication needs to be kept open between the caseworker in charge of the group activities and the caseworkers who work individually with the foster parents.

10. The principle of confidentiality of information must be respected in regard to children and foster parents, although in group activities the foster parents will inevitably come to know a good deal about each other.

To involve the foster parents in planning the group program, the agency called a meeting of eight couples who had expressed an interest in participating in such planning. At the meeting, the group was officially designated as the Foster Parents Planning Board. This board, now expanded to include 12 couples, still contains five of the original eight. Over the years it has worked with the staff in developing and coordinating the educational and social activities in a greatly expanded program for foster parents. Step by step, the program has grown until today it includes an annual institute, monthly discussion groups, an annual series of study workshops, and a variety of informational and social activities.

Experience in learning

The annual foster parents' institute was the first project planned. The first institute was held in October 1960; the eighth will be held in September 1967. The institute is always held on a Sunday evening and is attended by foster parents, staff, and board members. The foster mothers take complete responsibility for preparing a dinner for the entire group. In doing so, they have learned to work well together.

Following the dinner, a topic for discussion is presented through a film showing or a production of one of the Plays for Living, or by a speaker. After the feature presentation, small groups led by staff members and foster parents provide opportunities to discuss the points made. Subjects selected for the institutes have been: (1) The "Normal" Needs of Children; (2) The Foster Parent, Caseworker, and Community; (3) The Placed Child; (4) The Religious Life of the Child in Placement; (5) Handling the Adolescent; (6) The Unmarried Mother in Today's Society; (7) The Deep Well—Life in Foster Care; and (8) The Educational Deficits in the Placed Child.

In developing the format for these institutes, the agency considered the following points: This type of meeting might satisfy the needs of those foster parents who wanted some agency connection and some opportunity to learn more about the principles of caring for foster children, but who did not necessarily wish to attend a series of meetings. It might whet the appetite of other foster parents for more programs of an educational nature. It might break down some of the barriers between foster parents, caseworkers, and the agency's board and contribute to a cross-fertilization of ideas among them. It might help fill the social void in the lives of some of the foster parents and help them develop an esprit de corps. It might give the members of the Foster Parents Planning Board a sense of accomplishment.

Subsequent experience indicates that this annual event achieves a measure of all these goals.

Stimulated by the first institute to want more group activities, the Foster Parents Planning Board asked for a series of discussion meetings open to all foster parents focused on foster family life education, and followed by a coffee hour. Such meetings, initiated in 1961, are now held every month for 6

months of the year. Held in the evening, they are attended regularly by about a third of the parents.

At first, these discussion meetings centered almost entirely on two topics, the agency in general and the natural parents of children in care, both topics emotionally charged for the foster parents. In the early sessions, they revealed a lack of knowledge about the agency, its staff, and its place in the community's social welfare structure. In discussing the natural parents of children in foster care, most of what the foster parents had to say was negative and hostile.

As time went on, the foster parents who attended these meetings developed a deepening appreciation of their place in the agency's constellation of services. They also began to examine more realistically the source of their hostility toward the children's parents and to show an increasing awareness of how their negative attitude tended to loosen the children's ties to their parents and to themselves. They also gradually became interested in learning more about the "why" of children's and adults' behavior, including their own.

Over the years, the foster parents have revealed in their group discussions an increasing thirst for knowledge about the origin of behavior and a desire to identify themselves more closely with the agency. In these meetings, they have learned much about the structure of the agency and its services from members of the agency's staff, including the casework supervisor who conducted the meetings, the agency's administrator, the psychologist, the psychiatrist, and the tutor; and about the dynamics of children's behavior and ways of handling behavior problems from other professional persons in the Philadelphia area, as well as from members of the agency's staff.

The workshop series

In 1965, some of the foster parents expressed an interest in having an opportunity for a deeper learning experience. They were backed by the Foster Parents Planning Board, which pointed out that most of the foster parents had never participated in the kind of planned educational program professionals are used to. Plans for an experimental workshop series ensued. This was designed to cover eight 1½-hour sessions centering on an analysis and discussion of case material, under the leadership of a caseworker, at the end of which each foster parent would turn in a written report. It was decided to restrict participation in the workshop to 10 couples who were caring for preschool or school-age children and to select those who were the first to apply after the series was announced.

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As a topic for the series, the planning board chose "The World of Foster Care" as one broad enough to give the leader leeway in the presentation of material and to provide many stimuli for discussion.

Four more couples applied for the workshop than could be accommodated. Of the 10 couples selected, six had been foster parents from 8 to 13 years. Seven couples attended regularly; three had to drop out because of unforeseen circumstances that arose in their families.

The case material centered on a 5-year-old foster child, Jimmy. Before each session the participating foster parents were sent portions of the case to read and were asked to consider certain aspects. They also received a summary of the previous session, prepared by the leader.

The discussion focused on the following aspects of the case:

1. ***The child:*** his behavior patterns before and during placement; the possible meaning of this behavior; the "normal" behavior pattern of a 5-year-old child and what constitutes deviant behavior; the developmental tasks of children from ages 1 to 5; the modes of expression used by a child to release fears and anxieties—his grief and "mourning" following placement and his demands on the foster parents during this period; a child's feeling of guilt because he created the problem necessitating the placement.

2. ***The natural parents:*** the background and history of Jimmy's parents; the cause and effect of the interaction between his parents; parental attitudes affecting Jimmy's development; the meaning to parents and child of the parents' impaired capability for being parenting.

3. ***The foster parents:*** examination of the attitude of Jimmy's foster parents toward his own parents

and their reasons for becoming foster parents; discussion of the possibilities and limits in foster parenthood as a way of continuing to have the satisfaction of being a parent; discussion of what foster parents expect of a foster child.

4. *The caseworker:* the role of the social worker in the child's experience before and during placement; the significance of the social worker to the child, the natural parents, and the foster parents.

As anticipated, in the discussion most of the participants' understanding, sympathy, and compassion went to Jimmy. Afterward, the foster parents cited this part of the workshop as being especially helpful as a "baseline" for dealing with their foster children. As one pointed out, "We tend to forget all that we go through in growing up."

In the sessions on the natural parents, the foster parents exhibited surprisingly little anger toward the parents of foster children and a great deal of empathy with them as people. Perhaps this empathy developed in part as a result of their previous discussions in the monthly group meetings. Perhaps it was not impeded by feelings of hostility because the parents being discussed were not those with whom any of the foster parents in the group had to deal. Perhaps it also came from learning about the experiences these parents had endured and recognizing in them elements of their own life experiences.

On the whole, the workshop participants revised their attitude toward the caseworker during the discussion of Jimmy's case, although they continued to express lingering fear that the caseworker's closeness to Jimmy could impair his relationship to his foster parents. They frequently observed that the caseworker was the connecting link between all parties in the case and that her work was especially important in the preplacement period—a new idea for two of the foster parents who had once been used chiefly for emergency placements. They also observed that the positive relationship that evolved between the caseworker and Jimmy, a highly mistrustful child, was a first step in developing his capacity to relate to adults at all.

The greatest struggle that took place in the workshop revolved around the foster parents' ideas about themselves and their reasons for becoming foster parents—the question of whether they did so to "do good" to another person or to achieve self-fulfillment. In trying to face the question squarely, they talked about the way foster parents seek to avoid hurt by not allowing themselves to love the foster child completely lest the child be returned home, and about their pain at being frequently reminded that the child is not really their own.

This first series of workshops underscored the importance to both the participating foster parents and the agency staff of continuing efforts to develop the skill and understanding of the foster parents. The foster parents found that the series had helped them to bring out and deal with their anxieties as foster parents. The minutes of each workshop session, prepared by the leaders and shared with the foster

Foster parents meet at the office of the Association for Jewish Children, Philadelphia, to discuss their problems in foster care.

parents and their individual caseworkers, deepened the caseworkers' insight into the motivations of foster parents and hence increased their ability to build positive relationships with them.

At the foster parents' request, workshop series were again held in 1966 and 1967 with the respective topics, "The Home Study," and "Children's Behavior Formation and Common Causes for Misbehavior."

In the 1966 series, again led by an agency caseworker, the discussion centered on the record of an actual foster-home study and emphasized the many factors and interrelationships involved in the evaluation of a foster home, an analysis of the matching process, and the weighing of positive and negative qualities in a family in determining whether and how their home will be used by the agency. The participants in this series underscored their need for agency support in dealing with a difficult child and showed increasing appreciation of the similarities and differences between caring for foster children and one's own children.

The 1967 series, led by a psychiatrist, focused on normal and abnormal child development, the parental role in the creation of aberrant behavior, the deviations in behavior to be expected of children separated from their parents for any reason, what can be expected of children placed in foster care, and ways of dealing with difficult behavior in such children. So many foster parents expressed interest in participating in this workshop that the enrollment limit was extended from the usual 10 to 15 couples.

Other activities

In addition to the educational program, the agency, with the help of the Foster Parents Planning Board, has developed a number of other activities designed to bring the foster parents closer to the agency and to each other. These include:

Welcome teas, held intermittently to introduce new foster parents to the activities for foster parents, are organized by a committee of foster parents. As soon as the agency has approved a couple's home as a foster home, the foster parent who heads this committee sends the couple a note of welcome, following it shortly afterward with an invitation to a tea.

A newsletter, issued every 3 months to keep foster parents informed about the agency, the foster parents' activities, and community programs connected with child welfare. It is written by the agency's public relations director with the help of an advisory editorial committee of foster parents.

A manual for foster parents, developed at the suggestion of the Foster Parents Planning Board, describing the principles and procedures of foster care. A committee of foster parents met regularly with a member of the staff for 18 months during 1965–66 to write the manual.

A transportation committee, composed of foster parents, arranged transportation to activities for foster parents for those who otherwise could not attend.

In conclusion

No formal evaluation has been made of this program of group activities for foster parents. However, the agency is convinced that it has strengthened the foster parents' identification with the goals of the agency—particularly among the 44 couples (approximately 60 percent) who have consistently participated in some part of the educational program. The agency is also convinced that the placements of several deeply troubled children have been sustained through the support and understanding their foster parents have gained though the program and the hazards of replacement thereby avoided. Many foster parents have said that they feel better equipped to cope with their foster children and more certain of their ability to carry out the role of a foster parent because of their participation in the program.

As the foster parents have experienced recognition as quasi-professionals, they have broadened their interest in the welfare of children in general. Some of them, at their own suggestion and with the approval of the agency's board of directors, conduct a yearly campaign called the Donor Fund Project to raise money for the agency's scholarship fund. Others are working with civic groups in behalf of children, writing to legislators to secure better public programs, including better standards for public assistance. Bringing the foster parents closer to the agency has increased their awareness of the complexity of personal, interpersonal, and social problems behind a child's need for placement away from home.

GROUP LEARNING FOR FOSTER PARENTS

II. IN A PUBLIC AGENCY

ADOLIN G. DALL

Five years ago, the Bureau of Child Welfare, New York City Department of Social Services, faced with a loss of foster parents, began a program which, though small, has demonstrated the possibility of helping discouraged foster parents through group discussions to renew their confidence in their ability to handle difficult behavior. Among the foster parents who have participated with intense interest have been several who had become strongly resistant to help from the supervising caseworker.

The bureau established the Division of Foster Home Care 18 years ago to make direct, long-term placements of children needing care away from home. Until then, all such placements in New York City had been made by voluntary agencies under a purchase-of-care arrangement with the bureau, but these agencies had been unable to meet the needs of many children, particularly Negro Protestant children. Because most of the children placed by the division in its early years were infants or toddlers, many of them are still in foster care. Therefore, many of the 1,200 young people in the division's care today are adolescents.

Over the years, the rapid turnover of social workers on the agency's staff, the lack of professional training and experience of the new caseworkers, and the growing number of adolescents in care combined to make many of the foster parents resistant to working with the caseworkers in their behalf. An increasing number of foster parents, especially those with teenage foster children, began to doubt their ability to continue to care for their foster children. Some discontinued care, thus requiring the agency to replace the children. These foster parents were mature, dedicated people, but they were overwhelmed by the difficulties of dealing with the erratic behavior of adolescents—behavior aggravated in many instances by early childhood deprivations and by the racial unrest in the neighborhoods where many of the foster parents lived.

Therefore, in 1962, the foster care division initiated a series of group discussions with selected foster parents, using as group leaders two members of its supervisory staff, both professionally trained social caseworkers. With the help of inservice training and consultation from a faculty member of the Columbia University School of Social Work, these caseworkers have met regularly for periods of 6 weeks with groups of foster parents, usually in the communities where the foster parents live. Thus far, only 45 of the agency's 550 foster parents have participated in the group discussions, but these have included some of the agency's most discouraged and frustrated foster parents.

From the beginning of the program, the group leaders have kept the caseworkers who deal individually with the foster parents informed of their plans and of the groups' progress. No foster parents have been invited to participate in the groups without preliminary discussion between the group leaders and the foster parents' caseworkers.

At first some of the caseworkers expressed fears about what group participation might do to the individual relationship they had built up with the foster parents, but these fears obviously diminished as the group sessions proceeded. The group leaders have always been available to the caseworkers for individual conferences about particular case problems

Based on a paper presented at the 1967 Forum of the National Conference on Social Welfare.

that have come to light during group discussions.

A brief description of the Center Village Group will illustrate both the objectives and the effectiveness of this group discussion program.

The group

The Center Village Group consisted of 14 foster mothers and two foster fathers whom the caseworkers had had difficulty "reaching." All resided outside the city, far from the agency's office. They were primarily of low-middle socioeconomic status. Twelve were Negroes and four (two couples) were Caucasians. Nearly all had been foster parents for many years, and many of their foster children were teenagers.

Some of the group leader's goals were:

- To give the foster parents an opportunity to express and work out their anxiety about foster care.
- To give the members an opportunity to gain support from the experience of finding that other foster parents had problems similar to their own.
- To heighten the foster parents' identification with the agency.
- To improve the care provided the foster children by increasing the foster parents' skill in child rearing.
- To increase the foster parents' sense of self-worth and so to enable them to accept their foster children more fully.
- To strengthen and supplement the caseworker's efforts to help the foster parents with their child-rearing problems.

At the first meeting, the leader told the group members that they would be meeting for six sessions at 2-week intervals to work together on their child-care problems. She pointed out that the meetings belonged to the foster parents and that all discussion would be based on what they felt was important. From the beginning of the discussion, the foster parents recognized that they had difficulties in common. The following is a condensed excerpt from a report of their first meeting:

The group members talked for a while about how difficult it was for them to tell their foster children about their real parents. Then Mr. T spoke up. His voice was calm when he started, but as he proceeded it became chocked with emotion. He said that he was a stepchild, but as a child he had not been told of this. Until he was 13 years old, he thought that his stepmother was his real mother. Then a distant relative had told him that his real mother was not only still living, but was living in his own neighborhood.

Describing the pain of this sudden discovery, Mr. T said he would never want this to happen to his foster children. There was a hushed silence in the room; but the expressions on the faces of the foster parents showed that Mr. T had the members' sympathetic understanding. The leader supported Mr. T by saying that being told about this experience had helped the group members to comprehend more fully what a foster child may have to face if he does not understand who he really is.

At subsequent meetings the group members helped each other with their common problems in child care in many ways. They also helped the agency learn more about what foster parents were up against and as a result brought about some changes in agency policy. For example, at the fourth group session, they decided to petition the agency to increase its clothing grant.

A foster mother spoke of the inadequacies of the clothing grant. She said her 10½-year-old foster daughter wears very large sizes . . . yet the money the agency gives her for clothing is computed on the basis of the child's age rather than her size. Then nearly all the group members complained that clothing their foster children properly was a real problem for them. One said, "If you buy cheap clothing, it does not wear." Another pointed out that older children have to have a "say so" in the selection of their clothes or they just won't wear them. One foster mother said angrily: "It is impossible—the clothing allowance must have been figured out 15 years ago." Another said that the problem was that "the agency expects you to buy at inexpensive chain stores, and those cheap things will not last. It's throwing the money out."

Pointing out that all of the group members seemed to have the same problem, the leader asked, "What have you done about it?" One foster mother responded bitterly, "We tell our caseworkers."

Mrs. A, the most hostile group member, said that her caseworker just tells her if she spends more money than she should, she can take it out of the next clothing check. She pointed out that this was no solution, since it would only shorten the amount of the next check, and she added, "It just doesn't work out. I have to use my own money."

The leader asked, "What do you think you might do about it?" A group member answered helplessly, "What can we do?" Then one foster mother asked hesitantly, "Could we send a petition to the director?"

The rest of the meeting was spent in drawing up the petition. The agency had been considering increasing the foster children's clothing allowance, but the foster parents' petition undoubtedly helped hasten the process.

As the meetings of the Center Village Group progressed, the themes introduced by the foster parents included the meaning of the foster child's therapy

to the foster family and the foster child, the problem of frequent changes in caseworkers, the trauma experienced by the foster children and foster parents when separation takes place, and the problems of adolescence. The group members expressed their opinions and feelings candidly. Most of them began to see how frustrated they felt when they failed to meet the needs of their foster children.

The leader learned not to get ahead of the group, but rather to help the members to delve more deeply into each "theme" or problem introduced into the discussion. When appropriate, she confronted a group member with the meaning of what he had said or supported an emotionally overwrought foster parent, but, for the most part, she concentrated on helping the group members help each other. Periods of silence became less threatening to the leader as she came to realize that much of what happened at a group meeting was not verbal, that facial expressions, gestures, and withdrawal were all revealing signs of the degree of a person's progress.

In conclusion

Because of the great variety of circumstances and events that can affect what happens in foster care, evaluating the overall effects on the welfare of children of a group program for foster parents is difficult, if not impossible. However, we have found that well-conducted group discussions can sustain the interest of foster parents, for the attendance record in three of our four series has been excellent. Moreover, caseworkers have noted improvements in their relationships with some foster parents after they have attended the group meetings.

Our observations lead us to believe that—

1. Foster parents who felt threatened by their neighbors' negative attitude toward foster care have gained a feeling of support from identifying with each other as members of a group.

2. Foster parents who have been hostile and difficult to work with in a one-to-one relationship have been willing to discuss their problems of child management with other foster parents.

3. In general, the participating foster parents have gained perspective on their foster-care problems through learning about the problems of other foster parents.

4. The foster parents have often worked out ways together of handling the typical behavior problems of childhood and adolescence.

5. Some of the participating foster parents have formed friendships with each other that have led to friendships between their foster children.

The learning has not all been on the side of the foster parents, for through this experience the agency has increased its understanding of the needs of foster parents and ways of dealing with them. For example:

1. Certain aspects of foster care stood out as problems with which even foster parents of long-standing need continuing help—especially the foster child's need to achieve a clear conception of his identity and the foster parents' fears about losing the child.

2. Many significant aspects of foster care remained untouched or came up only when the participants were leaving, thus indicating a need for continuing the groups beyond the allotted six sessions.

Thus far, the agency has held four series of group discussions for foster parents, each group containing from eight to 16 members, chiefly foster mothers. Because the meetings are held during normal working hours, only two foster fathers have been able to attend regularly. This we see as a shortcoming, particularly because of the importance of the role of the foster father in the life of the adolescent foster child.

The agency, however, has a real commitment to the group method as a helping process. In addition to its work with groups of foster parents, it is now holding group counseling sessions with adolescent foster children and is planning meetings with the natural parents of children in foster care. One of the latest groups formed consists of foster parents of adolescent boys who are having their own group counseling sessions with an agency staff member. The agency's goal is to have the staff members of the foster care division eventually develop such skill in working with both individual parents and groups that they will feel free to use either method.

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introducing FAMILY PLANNING CLINICS to LOUISIANA

JOSEPH D. BEASLEY, M.D. ● CARL L. HARTER

In these days of mushrooming social research, many people have voiced concern about the amount of research effort that results only in tomes on library shelves, the implications of their findings for community action buried in the stacks. Research, however, that is specifically related to a service goal can become the foundation not only for identifying community needs but also for building the services to meet those needs in a way that offers opportunity for further research. Thus, in Louisiana, an inquiry into the attitudes of various groups of the State's population toward family planning has resulted in the creation of the first family planning clinics in the State. These clinics are not only providing poor people with a service never before available to them but are also producing data that, when systematically analyzed, may have important implications for the design and operation of family planning clinics for disadvantaged people elsewhere.

The background

In 1964, no organized family planning clinics, either public or private, existed in Louisiana, and the State's progress toward formulating a policy concerning this type of health service was at a standstill. At that time, section 14:88 of the Louisiana Criminal Code, as interpreted by the attorney general in 1932, made it a felony to disseminate information about contraceptives or any birth control measures. While persons who received medical attention from private physicians could usually get help with family planning if they so desired, the "medically indigent" people who attended public health centers and public hospitals had no way of obtaining such service. Legislative efforts to change the situation were of no avail. A bill introduced in the lower house to authorize the State Board of Health to start and maintain community educational programs focused on family planning was reported out of committee with no recommendation and was thus, in effect, killed. Thus, it became obvious that if any break was to be made in this stalemate, reliable information about the need for family planning services would have to be secured. Therefore, the Population and Family Studies Unit of the Tulane University School of Medicine's Division of Maternal and Child Health applied to the Children's Bureau for Federal funds to support such an investigation.

The project's first effort was to obtain data, through a questionnaire administered by personal interviews, from a "probability sample" of 368 men who had ever been married and 540 women who had ever been married or pregnant, aged 15 through 45, in New Orleans. (A "probability sample" is a group selected through a special sampling technique to be accurately representative of the total population. In this instance, 42 percent of the 908 persons in the sample were Protestant; 56 percent, Roman Catholic; and 2 percent, subscribed to other faiths.) The questions

they were asked were designed to elicit information on: (1) The respondents' knowledge of, attitude toward and practice of family planning; (2) the differences in fertility among different segments of the population; and (3) the family structure and family stability in two generations. Preliminary analysis, made in the summer of 1965, of the data secured from these questionnaires provided the following statistics:

- 71 percent of the women interviewed and 81 percent of the men did not know enough about the ovulatory cycle to know that the fertile period in the woman is approximately the middle 7 days between two menstrual flows.

- 34 percent of the women and 32 percent of the men did not know that pregnancy results not just from intercourse but from the union inside the woman of a male sperm with a female ovum.

- 12 percent of the women and 5 percent of the men did not know of any natural, mechanical, or chemical methods of preventing conception; another 12 percent of the women and 15 percent of the men knew of only one method.

- 40 percent of the women and 40 percent of the men said they would like to have more information about family planning methods; and 38 percent of the women and 45 percent of the men either said they had sufficient knowledge of family planning methods or were sterile or in a sterile union.

- 91 percent of the women and 91 percent of the men said they believed that couples had the right to decide for themselves when to stop having children.

- 92 percent of the women and 94 percent of the men said they believed that family planning services should be made available to the medically indigent.

- The number of pregnancies reported by the women came to an average of 3.30; their unplanned pregnancies, to 1.62. The men reported having "fathered" an average of 3.39 pregnancies, 1.35 of them unplanned.

These findings suggested that a large majority of the population believed that more family planning services should be available, especially for people who cannot afford private medical care. Many of the women had indicated that they would use clinic services if they were available.

The data also showed that one-half of the 142 Negro women in the sample had been pregnant before marriage, and that 31 of them were still single at the time of the birth of their first child. Among the 398 white women, 25 said they had had premarital pregnancies, and 2 said they had had a child out of wedlock.

Although further examination of the data is required to be sure, preliminary analysis suggests that women who begin their families with pregnancy before marriage are contributing more to the Negro birth rate than are those who begin with marriage. Such families tend to remain disorganized, for when a young girl gives birth to a child out of wedlock her chances of forming a stable union are delayed if not considerably reduced—prospective husbands must be able to support a child as well as the mother. Therefore, an economic drain on the mother's family usually continues for some time. Moreover, the family hardly has time to recover from the economic drain of raising one generation before it must turn to the problem of supporting still another generation.

There is also some evidence to suggest that the children of families that begin with an out-of-wedlock birth early in the mother's life in turn tend to begin families out of marriage at an early age, thus making for a rapid turnover in generations. As a result, disorganized families become an increasing proportion of the population as a whole.[1]

Armed with these findings, the Population and Family Studies Unit worked with the State Board of Health to secure a reinterpretation of section 14:88 of the Louisiana Criminal Code. In August 1965, the State's attorney general issued a reinterpretation, subsequently approved by the Governor, making it legally permissible to operate family planning clinics in Louisiana if they were under the

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supervision of physicians. This paved the way for the establishment of pilot family planning clinics for the study of the medical and social factors in the acceptance or rejection of family planning methods and services. Within a month, the Lincoln Parish Family Planning Clinic was in operation.

The rural clinic

The Lincoln Parish Family Planning Clinic, the first family planning clinic in the State, was established by the project in cooperation with the Louisiana State Board of Health as a part of the regular services of the Lincoln Parish Health Unit. Lincoln Parish, a rural parish (county) in northern Louisiana, was selected as the site for the first clinic and program because (*a*) the "clinic eligible" population was small enough (approximately 1,000) that everyone in it could be contacted and served in less than 2 years and, also, small enough to permit trial-and-error changes in the program's operation without disrupting service; (*b*) there was a high degree of cooperation between the personnel in the public and private health agencies in the area; and (*c*) the parish had characteristics typical of other rural and semirural areas in the South.

During the first 6 months of its operation, the clinic restricted its service largely to mothers who were in the postpartum period of childbirth. During this period, the project also conducted a survey among 249 Lincoln Parish couples who had had a child in the previous 5 years. (In this probability sample, 99 percent of the couples were Protestant and 1 percent, Catholic.) The same questionnaire was used as in the New Orleans survey and for the same purpose: To obtain data that could be used as a baseline in establishing procedures and guidelines for a parishwide family planning program. Completed in December 1965, the survey produced the following preliminary data:

- 87 percent of the women and 82 percent of the men did not know enough about the ovulatory cycle to know that the fertile period is approximately the middle 7 days between two menstrual flows.
- 47 percent of the women and 37 percent of the men did not know that pregnancy results from the union inside the woman of a male sperm with a female ovum.
- 15 percent of the women and 3 percent of the men did not know of any natural, mechanical, or chemical methods of preventing conception; and another 19 percent of the women and 40 percent of the men knew of only one method.
- 71 percent of the women and 66 percent of the men said they would like to have more information about family planning methods; another 21 percent of the women and 32 percent of the men said they had sufficient knowledge of family planning methods or were sterile or in a sterile union.
- 96 percent of the women and 87 percent of the men said they believed that couples had the right to decide for themselves when to stop having children.
- 99 percent of the women and 98 percent of the men said they believed that family planning services should be provided for the medically indigent.

On the basis of data from this survey, as well as data from the health department's vital records that identified mothers at "high risk" of having complications in the event of another pregnancy, the project decided to broaden the scope of the clinic's services. Therefore, on March 1, 1966, the services were opened to all medically indigent mothers and married women in Lincoln Parish. Before this was done, however, the project's director got in touch with the religious, political, civic, and medical leaders of the area to inform them of the reasons for the clinic's establishment. All agreed to the principles that were to govern the clinic's operation.

In the clinic, all patients receive instruction on: (1) the meaning of family planning and its relationship to family welfare; (2) the mechanism of fertilization and subsequent fetal development; (3) the types of available medically sound birth control methods and the advantages and disadvantages of each; and (4) the official positions of the larger religious denominations on family planning. After this comprehensive instruction, all patients have the opportunity, in private consultation with a clinic staff member, to decide individually which birth control method they want to use, if any. Patients who choose the rhythm method are given detailed instructions and continuing consultation on its use. Similarly, patients who elect the use of a contraceptive are provided with the appropriate equipment, instruction, and service. Since the program was developed as an integral part of a comprehensive maternal health service, all patients receive pelvic and breast examinations, a test smear for cancer, and, when appropriate, a postpartum evaluation.

Of the estimated 1,000 "clinic eligibles," 30 percent had received family planning information and services by September 1, 1966; that is, within 6 months after the clinic began full-scale operation. This amount of response in such a short period after the opening of the service suggests that the desire for family planning services indicated in the survey was real.

The project is now making the following studies in Lincoln Parish: (1) an experimental study of the effect of the method of recruitment and of the effect of "parity" (number of previous childbirths) on a woman's participation in a public health family planning program; (2) a comparative study of the effectiveness of two types of intrauterine devices in a public health family planning program; and (3) a fertility analysis, cost analysis, and analysis of service statistics.

The urban program

The next step in furthering the project's research on fertility and family planning was to try to establish and study a family planning program for the medically indigent population of a large urban area, specifically New Orleans.

The plan of action consisted of seven steps:

1. Determine the *Acceptability* of such a program to the community.

2. *Design* a program that would simultaneously provide adequate, efficient service to all eligible and interested patients and accumulate detailed, systematic data for medical and behavioral scientists.

3. Secure the *Support* of the community leadership—religious, civic, and political—for such a program.

4. Obtain the necessary *Money* to establish the program.

5. Put the program into *Operation.*

6. Evaluate the *Results* of the program and use these results not only to enhance the program but also to keep the community-at-large informed.

7. Make plans to *Extend* the program's services beyond the period of time encompassed by the study phase.

When the initial letters of each key word in these steps are combined, the result is the acronym "ADS MORE." We believe that such a program will indeed add more to the health care and economic and social well-being of persons in the community.

With regard to the *acceptability* (step 1) of a family planning program to the people of New Orleans, the Unit had already found, through the family and fertility survey made there, that nine-tenths of both Protestants and Catholics believed that family planning services ought to be available to the medically indigent. Furthermore, a majority of the respondents from the lowest socioeconomic group had said they would like to have more family planning information. In short, the opinions expressed by the people in the survey sample indicated not only that a public health family planning program would be acceptable but also that such a program was actually needed. In fact, 84 percent of the people in the sample had said they were in favor of the establishment of either a tax-supported or a voluntary family planning program.

In drafting the *design* of the proposed program (step 2), the Unit had two main objectives: (1) to provide clinical services to interested, eligible persons in a manner consistent with the dictates of their consciences; and (2) to produce data for evaluative purposes.

The clinical program was designed to provide the same type of individualized service as the Lincoln Parish clinic, but to do this through a central clinic and five satellite clinics. Similarly, the plan for accumulating detailed, systematic medical and behavioral data was based on the experience gained in designing data-gathering forms for the Lincoln Parish Family Planning Clinic. This consists of a system of recording data needed for both following the patient's progress and evaluating the program.

From the beginning of its research on fertility and family planning in New Orleans, the Population and Family Studies Unit kept appropriate city offices, including the mayor's office and the local health and welfare departments, appropriate voluntary organizations, and the two large universities in the State, informed of what it planned to do and why and presented them with findings from the survey as these were obtained. Building relationships with these groups took 2 years, but the rapport thus established brought strong community support for the proposed clinical program. The Population and Family Studies Unit received letters endorsing the principles of its proposal from the Orleans Parish Medical Society, the Family Life Apostolate of the Archdiocese of New Orleans, the Orleans Parish

Department of Public Welfare, the City of New Orleans Department of Health, the Louisiana Association for Mental Health, the Charity Hospital of Louisiana at New Orleans, the schools of medicine of both Louisiana State University and Tulane University, Total Community Action (the local community action program, or CAP, in the "war on poverty"), and the Greater New Orleans Federation of Churches. The proposed program also received approval from the Social Welfare Planning Council, which represents the major voluntary health and welfare organizations in the city, and the local affiliates of the National Association for the Advancement of Colored People, the Congress of Racial Equality, and the National Urban League.

To operate a service and research program on the scale envisaged for New Orleans, *money* had to be secured to supplement the funds the Population and Family Studies Unit was receiving from the Children's Bureau. Additional support was eventually secured (step 4) through grants made by the Ford Foundation and the Rockefeller Foundation to the Population and Family Studies Unit and by the Office of Economic Opportunity to Total Community Action. By April 13, 1967, the Unit could count on $2.1 million for operating the Orleans Parish Family Planning Demonstration Program for 3 years. To receive such funds and administer the program, a new nonprofit corporation was formed, the Louisiana Family Planning Program, Inc., with a board of directors composed of members of the faculties of the medical schools of Tulane and Louisiana State universities and of community representatives.

Program operation

The central family planning clinic opened in New Orleans on June 27, 1967. This marked the beginning of step 5—putting the plan into *operation*. The five proposed satellite clinics are expected to be providing services by late fall 1967 or early winter 1968. At present, the project's staff is preparing a procedural manual for use in training clinic personnel and to furnish to persons interested in learning about the details of the program. A similar manual has been prepared for the Lincoln Parish family planning program.

The basic data needed for evaluating the *results* of the proposed program (step 6) will be gathered with the use of a form for recording comprehensive data. In addition to the types of information usually sought in evaluation of a family planning service—for example, rates of acceptance and continuance of the various methods of birth control and changes in the fertility rate in the neighborhood served—the Unit plans also to conduct inquiries into: (1) what is involved in the acceptance or rejection of a family planning clinic by members of a medically indigent population; (2) the effects of informal communication on the use of a family planning clinic; and (3) the effectiveness of instructions about family planning.

With regard to step 7, making sure the program's services *extend* beyond the research period, the service aspects of the programs have been designed as integral parts of the regular health programs of the participating agencies—the two medical schools, the city health department, the Orleans Parish Department of Public Welfare, and the State Charity Hospital at New Orleans. The principles and methods of operation and the record-keeping systems worked out by the Population and Family Studies Unit as a result of its experience with the Lincoln Parish and New Orleans family planning programs will be the guidelines to be followed by the State Board of Health, the State Department of Public Welfare and the State Department of Hospitals as they make plans to include family planning services as part of their developing health programs. The Population and Family Studies Unit and the Louisiana Family Planning Program, Inc., will serve as the coordinating agents for the development of a statewide family planning program. Plans are also underway for the design to be used in an expanded and coordinated program of maternal and child health for the indigent mothers and children of New Orleans.

In summary, the family planning activities of the Population and Family Studies Unit, Tulane University, have simultaneously provided a laboratory for scientific investigations and an avenue through which the university could be of service to the community. The objective, both in research and service, is to make it possible for couples to secure the information and services they need to plan their families so that they will be in a better position to develop the potential of each of their children.

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an EDUCATIONAL PSYCHOLOGIST in a PSYCHIATRIC CLINIC

ROBERT FRIEDMAN

Poor schoolwork leads the list of complaints parents bring to orthopsychiatric clinics.[1] This is understandable, for our culture highly values formal learning. Success or failure in school greatly influences the behavior of children and the impressions they have of themselves and can critically affect the development of the ego. Clinical educational psychology, with its emphasis on the healthy development of the ego, has a special and essential contribution to make to psychiatric services for children and adolescents. The psychoeducational program described here is based on that proposition.

The setting

The program is unusual in that it operates not in a university, a hospital, or an independent agency, as psychoeducational programs usually do, but in a psychiatric clinic. The Department of Psychiatry at the Southern California Permanente Medical Group of Los Angeles, which conducts the program, offers comprehensive psychiatric inpatient and outpatient services at a central clinic on contract with several local labor unions, including the Retail Clerks and the United Auto Workers, AFL–CIO, and with Federal and State employees for service. In addition, the department provides consultative and educational services to the Kaiser Foundation Center for Child Psychiatry in Los Angeles, an agency offering low-cost, short-term psychiatric services to all 5-, 6-, and 7-year-old children in the community who are not adapting well in school. The department has more than 40 professional workers, including psychiatrists, clinical psychologists, psychiatric social workers, and a speech therapist.

The psychoeducational program was set up late in 1964 after the department had explored the idea of including psychoeducational evaluation in the clinic's regular program and had found that the staff was very much interested. Its first act toward this end was to engage me as an educational psychologist specializing in the clinical evaluation and treatment of children and adolescents of normal intelligence who have been doing poor schoolwork and as a consultant to develop and supervise clinical educational services. An educational therapist was added to the staff, part time, in May 1965, in response to the growing use of the psychoeducational service by the regular staff members of the department. Psychoeducational consultation, evaluation, and therapy were made part of the regular program of the department and the center shortly after the therapist was hired, and in September 1965 the department started a training program for school psychologists and took on two interns from a nearby university.

In effect, the inclusion of a psychoeducational consultant in the traditional clinical team of psychiatrist, social worker, and clinical psychologist adds a fourth member who contributes expert knowledge in the area of learning disorders and the problems of school adjustment. The person in this position is responsible for psychoeducational evaluation; supervision of psychoeducational therapy; spe-

cial consultation with parents, staff members, and school officials; and the training program.

Some overlapping of duties among specialists is inherent in the structure of a traditional clinic team, and the work of the two psychologists at first did overlap. Our clinical psychologist is responsible for psychodiagnostic services, including treatment, consultation, and training; the duties of the educational psychologist are described above. Although both specialists often give the same tests to measure intelligence, personality, and perceptual-motor skills, close cooperation between them has eliminated duplication and has improved the effectiveness of the work of the team.

The program

Our program, modified and improved through experience, falls under four major heads—evaluation, consultation, treatment, and training.

Evaluation. Complaints about a child's schoolwork are particularly frequent at intake and may come from the child himself as well as from his parents or officials of his school. To properly consider these complaints we must often do a comprehensive psychoeducational evaluation of the child's academic skill and intellectual ability, the psychological correlates of learning applicable to him, the effect of his personality on his attitude toward and involvement in the learning process, and what his family expects of him in school and its attitudes toward achievement in school. A key issue in this evaluation is the way in which the child relates to the demands of a learning task—the degree of anxiety it arouses in him, the means he takes to reduce stress, the degree of passivity or aggressiveness he exhibits toward the task and toward the examiner as a figure of authority, and any other behavior related to schoolwork.

In addition to giving standard educational tests, we also follow informal evaluation procedures. For example, we use sample schoolwork sessions as a test because they call for much interaction between the child and the examiner and afford the examiner an opportunity to study closely the child's reactions to stress and frustration. Through interviews with the family—individually and as a group—the examiner can determine the effect the family as a group and its members as individuals have on the child's performance in school. We discuss his problems with his parents or with his brothers and sisters, separately or with the child present. Now and then, we ask parents to explain or demonstrate the methods they use to help the child with his homework to determine whether the parents are providing the help in a constructive way. Interviews with the family as a group often uncover a specific relation between family dynamics and a child's performance in school.

In the first 18 months of the program, clinicians requested over 60 evaluations. Although specific recommendations for psychoeducational intervention or planning often followed these evaluations, sometimes the evaluation of a learning problem uncovered a condition calling for nothing more than a reassuring word to a child or his parents.

Consultation. We use the results of the evaluation in several ways. Sometimes we only report them to the referring clinician or discuss them at intake staff meetings. Frequently it is helpful for me to explain the results directly to parents in a conference with the clinician because the word of an "educational authority" often carries more weight than that of a clinician with parents who find it difficult to accept results and follow through on recommendations.

We often share with the school through written reports or informal meetings findings that teachers, principals, or school guidance workers can use to advantage.

I am available to the staff for special consultation about the many needs of their patients. For example, they may consult me about the merits of a school, for the right school is often critical in planning for some of the children we serve. When the issue of school placement is raised, I review information on available resources, including the experience we have had with these resources, and recommend a specific public, private, or residential school.

Occasionally, I have the unusual duty of acting as a cotherapist in a family therapy program when a case involves school problems that are exacerbating family tension, or when therapy for the child can be speeded up by involving the family more fully in treatment through concentrating on school problems.

Another of my duties is to make presentations to and to participate in staff meetings and seminars.

Treatment. With our patients—children and adolescents having trouble in school—we use psychoeducational therapy, a method of treatment centering on learning. (The term "psychoeducational therapy" as used here reflects a theoretical position put forward by my colleague, Edwin Strickler, and myself.) Our treatment includes the use of a wide range

Robert Friedman, an educational psychologist in private practice in Los Angeles, serves as a consultant on educational psychology to a number of psychiatric and child guidance clinics in the area: the Southern California Permanente Medical Group, the Kaiser Foundation Center for Child Psychiatry, the Reiss-Davis Child Study Center, and the Mental Health Development Center of the local affiliate of the Retail Clerks Union, AFL–CIO.

of practices, including remedial work, counseling, play therapy, and family therapy.

Remedial work to correct a lack of skill a child needs in school is an important part of treatment, but its results are not themselves the major goal. We emphasize, rather, making a positive change in the child's attitude, increasing his motivation, and modifying personality traits that negatively affect his adjustment to school. Our treatment is unusual in the scope of its theoretical conception and in the degree to which it is an integral part of a complete psychiatric service. For example, we provide psychoeducational therapy as a single treatment-of-choice and consider it as a primary, not an adjunctive, service. When the child's learning difficulty can apparently be resolved by tutoring only, we refer him to a school or another community resource offering the kind of service he needs.

More than 35 children and adolescents have been involved in the therapy to date. The therapeutic method we must frequently use at first is this: we try to establish a warm, accepting relation between the child and the therapist and to strengthen the relation by giving the child an opportunity to attain success in school. To help the child achieve this success, we must usually combine remedial teaching with opportunity for cathartic release of feelings by the child and for exploration and interpretation of emotions and behavior by the therapist. Getting the child to talk about his feelings concerning schoolwork and then getting him to see and understand the interaction between his feelings and his schoolwork is frequently the next step in therapy. As the child's relation with and confidence in the therapist grow, his academic skill usually improves. We find, however, that a skill mastered in a therapy session is not always used in the classroom. If it is not, then the discrepancy between performance in the clinic and in the school becomes the focus of attention and of the process of "working through." Exploring fears, inhibitions, disturbed ideas of object relations, a negative attitude toward authority, and difficult relations with family and other children may at times be the "content" of treatment. The therapist is always free to work with whatever behavior or feelings come out in the therapy session.

The case of Don D illustrates our usual method of working with children:

When Don began treatment at the age of 8, he was an extremely nervous boy and was very much afraid of facing schoolwork, especially reading. At first we gave him very easy material to read, which he was soon able to do. With success in reading, his stress diminished and he was able to reflect on and accept his feelings about reading—and even to say "I don't *want* to read." We then explored the reasons for his resistance to learning and found that his reading problem was tied up with denial of many important emotions, including his reactions to his mother's overprotectiveness and his father's harshness. We also found that Don thought that learning to read meant growing up and growing away from his mother. Also, Don had linked the denial of sexual matters and the ignoring of issues raised by curiosity about sex in his home to resistance to seeing words and sentences.

Gradually, the therapist helped Don overcome his sensitivity to visual stimuli connected with mother-son and man-woman relationships through the use of picture stories and puppet play. To help Don see that his negative attitude toward school was keeping him from reading as well in the classroom as in the clinic, we had him attend tutoring sessions with another boy with similar problems. The boys' spontaneous interaction and their comments about school and therapy focused attention on the attitude toward school that was keeping them from doing better work. These sessions helped Don become more comfortable with learning tasks at his grade, and after 19 months of treatment, he did satisfactory schoolwork. We also found that he was able to recognize, tolerate, and handle long-repressed and troublesome feelings and fear—an improvement we considered at least as important as the improvements he has made in his schoolwork.

Other examples of the use of these or similar methods in treating such children exist in the literature,[2-5] but the case of Stuart S, one of our clients, illustrates the use of an unusual method of treating a child with a problem in learning.

Stuart, a 9-year-old boy who exhibited great passive resistance to learning, had been exposed to much intellectualized talk in the home about feelings, emotions, and attitudes. A psychiatric social worker was seeing both his father and mother in individual therapy sessions. From the beginning of Stuart's treatment at the clinic, his therapist met his resistance forcefully and tenaciously with an attitude that said in effect, "You can do this hard work if you try, and I expect you to try." After a long struggle, which included many sessions in which the two said very little of meaning to each other (but in which there was much transactional content, that is, the child and the therapist "communicated" by silence, actions, or motions with each other), the boy was able to see the connection be-

tween his wish to remain an infant and his poor achievement in school.

The therapist speeded up the therapeutic process by involving the mother in several sessions with Stuart, getting the father to take part in the treatment hour as a teacher-authority, and holding several family group meetings. As a result, the father, who had been passive toward his son before treatment started, eventually assumed his duties as a father with Stuart and his change helped the child take a more aggressive attitude toward learning and improve his attitude toward and achievement in class.

Although we conduct most psychoeducational therapy individually, we do carry on some work with small groups because we recognize the potential value of work in a small group as a transition from individual therapy to the classroom, especially for children who have been excluded from a public school because of their unacceptable behavior. For the most part, such children are hyperactive, highly distractable, and disturbed, and they find it very difficult if not impossible to share the teacher's attention with other pupils, to work when other children are present, or to work or play with other children. If a child can acquire enough control to act as a social being in a classroom, at first with only one other child, later with several children, the probability of his returning to the classroom permanently will be greater. Our experience with a group set up for this purpose is encouraging, and group treatment is now part of our program.

Training. Recently revised requirements for school psychologists in California increase the emphasis on supervised internships. Because we concentrate more than most clinics on school problems, our clinic offers an appropriate placement for advanced graduate students. The training experience our clinic offers includes opportunities to attend intake sessions, treatment sessions, and seminar staff meetings, as well as to complete assignments for psychoeducational diagnostic studies, counsel parents, and conduct psychoeducational therapy. As a consultant, I closely supervise the work of the interns.

In addition to giving breadth and depth to clinical study, the internship enables the trainees to acquire a realistic idea of how a psychiatric clinic operates, because such a clinic is the kind of service to which they will make many referrals in their later work. In turn, they can pass on a better understanding of both the merits and limitations of psychiatric services to teachers and other school people.

At present, we have in training one school psychology intern from the University of Southern California and one from the University of California at Los Angeles.

A summing up

To sum up this report on the clinic, our experience with the program supports earlier findings regarding the merit of clinical educational services in the orthopsychiatric clinic.[6-8] In addition, I find that research on such significant questions as the influence of personality on learning and on the potential for treatment with psychoeducational therapy needs to be designed and carried through systematically.

The link between education and psychology offers many opportunities to use creative methods in working with a child in the clinic and in the school. I am firmly convinced that clinical educational psychology can make a significant contribution to a greater understanding of the dynamic interaction of teacher and pupil. What is the real challenge such a program must meet but to help all schoolchildren fulfill their potential for growth?

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an essay review . . .

CHILDREN COPE WITH CRISIS

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Dr. Robert Coles dedicates his book "Children of Crisis: A Study of Courage and Fear"* "to the children of a coming South," and he quotes the Biblical verse: "And Moses sent them to spy out the land of Canaan, and said unto them . . . see the land . . . and the people that dwelleth therein, whether they be strong or weak." Thus he sets the tone of his observations and reflections. He is concerned with the sources of strength and the ways in which children and their supportive parents, grandparents, and teachers struggle with the fear generated by the strife aroused during the process of school desegregation.

He writes as a man of deep sensitivity, reflectiveness, and love, and with the insight of an "anthropological psychiatrist" uncommonly receptive to people's feelings. His own strength includes an unostentatious autonomy and integrity that make it natural for him to describe children very simply, through their own language of picture and word, without substituting complex diagnostic clichés for fresh formulations based on insight.

Dr. Coles undertook his studies of the children caught up in the desegregation movement and "the people who nurture them, teach them, and on occasion fail them terribly" in 1958. He has continued to see many of the children and families periodically over the ensuing 9 years. His method of study is that of direct observation, "talking with people, listening to them, watching them—and being watched by them" and "taking a long time: enough time to be confused, then absolutely certain and confident, then not so sure but a little more aware of why one or another conclusion seems the best that can be argued [for]. . . ."

Dr. Coles tried to find out how children managed under stress, that is, abnormal and dangerous circumstances. Children and adults who entered the mainstream of the desegregation process, or were caught up in it, he believed, have "discernible cause to feel nervous, to develop . . . symptoms in both mind and body." He was interested in whether they did so and, if they did, how and when they did; and also who chooses which kind of danger and for what reason. His deepest interest was in learning what makes "for survival under stress, for endurance, for courage against grim odds; indeed, for plain good health. . . ."

He was also interested in what the child's mind makes of the world—of politics, race, and the power of money—and why one person is satisfied to make peace with the world while another takes the world on and tries to change it. He felt that as a clinician interested in what goes on "inside" others, he was "as qualified as anyone to go back and forth, to see how the two worlds (outside, inside) connect, blend, engage. . . ." That is, he wanted to understand the connection between a child's or a man's thinking and the world's state of affairs. So, he went into places where certain people were up against difficult times "so that their lives, like those of the sick, may have [had] something to teach the rest of us."

Dr. Coles' intellectual heritage is rich. He draws deeply from Erik Erikson's concepts and vision of the everyday relatedness of the human mind to social institutions and to history, and from the simplicity of Anna Freud's observations of English children under air attack and children salvaged from concentration camps, and her examples of combining observation with practical service. He also draws perspective from Tolstoi and a sharpened awareness from Oscar Lewis, Bruno Bettelheim, Faulkner, and Kafka. Doubtless these writers, along with an apparent Biblical heritage, contributed to the poise, grace, and dignity of his writing and of his feeling for people.

Self-image

Dr. Coles gives us vivid action portraits of young children, both Negro and white, who participated in the desegregation of schools in Atlanta and New Orleans and of their teachers and parents. Protesting and nonprotesting integrationists in the South and even segregationists are all presented with understanding.

He includes pictures drawn by two first-grade children, Negro Ruby and white Jimmie, as direct evidence of the everyday stress of being a Negro child in a rejecting white world. The drawings reveal both children's sense of the Negro child's incompleteness, inadequacy, or distortion through small figures drawn with shaky lines, missing fingers and features, and lack of vivid detail.

I found Ruby's pathetic representation of her self-image especially shocking in contrast to the clarity, vigor, and spontaneity of *colored children in a*

*Coles, Robert: Children of Crisis: A Study of Courage and Fear. Little, Brown and Co., Boston, Mass. 1967. 401 pp. $8.50.

colored world—as with children in Nigeria—and even in contrast to the vigor of many Negro children in a town like Topeka, Kans., where schools have been integrated for a dozen years.

Dr. Coles learned about the coping patterns of the Negro children not only from them but also from observant white children aware of their experiences. He learned that before desegregation George, who told about crying when a beloved Negro maid left his family when he was 5 years old, had completely identified with the Southern attitude toward race and with the Southern resentment toward Northerners who do not realize the love some Southerners have for the individual Negroes they live close to. He suggests that perhaps this background of early attachment, along with a native intelligence, underlay George's sensitivity to the behavior of Lois, the new Negro girl in his class.

George understood the girl's anxiety but was confused by her good humor. He observed her vigilance as she tried to see what happened around her while she was afraid to move her head and look. He was aware of the tension in the room, "so thick you can almost cut it," and said that the teachers were as nervous as the pupils. He thought that perhaps the girl's "silly smile" reflected her awareness that the white children were suffering too. He was aware of her loneliness: only one or two would sit near her; no one would work with her in the "lab" but the teacher.

George thought at first that the presence of Lois ruined everything for his class's last year at school. However, as time went on, he developed increasing empathy for her. He felt the strain was beginning to tell, that she tried hard to find a reason to smile but could not, so she sat there most of the time pretending to read or write. He even admired her way of holding back from revealing how smart she was because she was afraid it would make the others jealous and mad. He became aware of how strong her staying powers were.

In such reports, Dr. Coles shows us how deeply human both the white and Negro children were; how inexorably their human respect for courage, for one another's decency, slowly brought some of them together; how in many instances the experience of being together melted the rigidity of prejudice.

He tells about a white mother who invoked the Lord's name to give strength to her belief that every human being deserves respect; and about a Negro mother who drew support from the idea of an all-loving Lord and told her children when they asked about their color that "the Lord likes everyone because He makes everyone. . . . No one knows what color He is."

But the Negro child rejected by the white world struggles not only with the question of whether he is all right; he also struggles to get an explanation. A little Mississippi girl said, after drawing a picture of herself, "That's me, and the Lord made me. When I grow up my momma says I may not like how He made me, but I must always remember that He did it, and it's His idea. So when I draw the Lord He'll be a real big man. He has to be to explain about the way things are."

We see here the alert, sensitive child trying to make sense of an incomprehensible situation, part of the effort every child makes to achieve an orderly, intelligible conception of the world. The children were observant: "The colored don't get good streets with cement on them as easy as the white."

Supporting resources

The Negro parents tried to teach their children how to cope with discrimination. Said one mother: "We have to live with one another, black with white . . . you have to teach your children to know what's dangerous and how to stay away from it. . . ."

Tessie and two other Negro girls were the only pupils at school during their first year of "desegregation." All the white pupils had boycotted. Her grandmother remarked shrewdly: "I kept on telling Tessie she'd never have it as good again, all that building and teachers to herself and everything. Take advantage of the white man's mess, because it'll work for your gain, that's what I said to her when I thought she needed a little helping word here or there."

Tessie's mother wanted her daughter to go to a desegregated school but she worried about the strain of it upon her daughter and herself. "The truth is I might have taken Tessie out. . . . I held firm because my husband held firm, and we both held firm because of Tessie's grandmother . . . she never gets scared. . . ." Tessie's mother said: "I try not to go beyond each day . . . if you can get your strength up for the present, the future will take care of itself." She answered abuse with silence.

Tessie's grandmother told her, "It doesn't even matter if it's easy or hard for you at school. It's *going* to be hard, some time or other it's going to be hard in this world and Tessie girl, you'd just as well start getting used to it now." To Dr. Coles, the grandmother said, "Tessie and I eat grits before going through those mobs and we eat ice cream after we come home from them." Thus the wise grandmother helped with perspective and earthy sustenance to maintain the nerve of her beleaguered granddaughter.

Tessie had her own resources, too; she was a fierce, stubborn, willful child. But she *became more contained* once she started school under the watchful eyes of the mob. "She liked to draw . . . she could give representation to her tormentors, to her dread of their vengeance, to her feelings of weakness, to her natural wish to escape, to be a little white girl living a less turmoil-filled life." This capacity to clarify her feelings and thus to master them was for her another major resources for coping.

She kept the drawings for a while, looked at them from time to time, and absorbed them; then when she had come to terms with the fantasies they represented, she gave them to Dr. Coles. "I know it's scary sometimes . . . but not as scary as what I can dream up. . . . So I told Granny that as bad as they make it for us, the stronger I'll get, because I'll beat them to the punch by imagining it even worse than it is . . . everything goes fine with the whites until I get sick and stay home. Then, when I come back to school, it takes them a day or so to get used to me, all over again." She helped herself by contrasting reality with fantasy. Having mastered her own fear, she could even understand the plight of the white children.

Effects on children

Dr. Coles makes the nature of the struggle vivid to the reader—the constant threats "We'll kill you . . . poison you . . . choke you. . . ." He gives accounts of terror, humiliation, repudiation beyond any told in newspaper or TV accounts. Yet, he reports little evidence of children being overwhelmed by

their experience or becoming physically or mentally ill, disorganized, aggressive. Perhaps no breakdown occurred because of the self-selection process that permitted only the most confident Negro parents to sign up for their children to attend desegregating schools; or because of the "screening" process used in some schools to eliminate "poor risks" and select the most stable children.

Dr. Coles is also concerned with another problem: to what extent is it all right to allow children to participate in the movement, to face the mobs? His answer: "When we find out what happens to them if they don't protest, we will find out about children in daily subjection who have been asked to forfeit their freedom by the decision that they must endure tyranny rather than face 'danger' or 'trauma'. . . . What can be worse psychologically and spiritually for any child?"

Yes, but . . .

It may seem strange for me to add a "Yes, but . . ." to Dr. Coles' presentation. But I wonder whether this emphasis does not overlook the question of who can afford to battle for the group. The Armed Services with good reason exclude men vulnerable to breakdown. In the internal war of desegregation, some such screening may also be needed. In the South it has been provided directly by some principals and indirectly by others who asked for applications. In the North, where some large-scale integration has been attempted by arbitrarily assigning children to schools out of their own neighborhoods, there may be more serious effects on *some* children: fatigue or a divided life in which the range of standards and life styles in different settings is too great for young children to integrate.

Dr. Coles reminds us that children participated in the Underground in Europe, boycotted Quisling's teachers in Norway, sang songs of protest in Danish schools, helped derail German trains in Holland, and even murdered Gestapo agents in France. They fought for survival and formed gangs to seek food and shelter to support one another. Some learned in German concentration camps the "value of freedom and of life itself." But many did *not* survive, and we must not forget this.

Rugged children may thrive on challenge. But when we focus on the strong, we forget children all over the world who do not survive—those who die of marasmus or are mentally stunted and depressed in foundling hospitals; those who fill our child psychiatry clinics with more troubles than can be eased; those who grow into adults without hope, who join the ranks on skid row or fill our prisons.

The value of emphasizing the toughness of the survivors is to illustrate how amazingly wide the range actually is from strength to vulnerability, how hard it is to gauge the line between adversity that strengthens and adversity that destroys; and to challenge us to study still more intently the coping efforts and support that contribute to survival. Dr. Coles' eloquent account of the survival techniques of the strong is a gift to the science of human development, of child psychology and psychiatry, of social change.

But, to have a complete picture, we need a comparably sensitive record of what has happened to *all* the children in New York City who were "bussed" out of their home neighborhoods to integrated schools. Here we might find not only heroes like those Dr. Coles has described, but also victims of desegregation in terms of educational and emotional losses.

As I read the book, I was impressed by several recurrent themes:

1. The support given by Southern *mothers*, Negro and white, to their children who were carrying the burden of integration—a support often rooted in a deep commitment to a good education; the tough, sometimes stubborn realism, frustration tolerance, capacity to take risks, typical of these mothers and their husbands (often more passive) and in some cases the children's grandmothers or their teachers and ministers.

2. The struggle of children to learn to accept and understand the different colors "God made" people to be.

3. The learning process and adaptational steps involved in coming to terms with desegregation, especially as these steps were imposed upon a few recalcitrant fathers who at first opposed their sons' going into the civil rights movement.

4. The role of empathy, compassion, and affection in helping white children and adults appreciate the experience of the Negro children—both in those who were freely moved by these feelings and those with immobilizing conflicts between such feelings and their prejudice.

5. The suffering, disillusionment, and despair that sometimes overcame but did not stop the young people who had hoped to accomplish visible changes rapidly and who came to realize that the task of integration would take years or a generation or two.

6. The inner vitality, release of energy, and integration of personality that so many children seemed to derive from the experience of living, acting, feeling in a way consistent with their ideals and beliefs. I have seen this in other groups deeply committed to a goal—in Israel in the early years of independence and in a new college committed to uniquely individualized education. Fighting for what one believes to be right mobilizes energies from all layers of the personality—conscience, ego, and primitive forces of love and aggression. Moreover, the opportunity to defeat an enemy such as prejudice in righteous battle helps a person to transcend the small bitter conflicts that so often block the full use of personal resources.

7. The progressive stimulus of progress itself.

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collected readings

PERCEPTUAL DEVELOPMENT IN CHILDREN. Edited by Aline H. Kidd and Jeanne L. Rivoire. International Universities Press, New York. 1966. 548 pp. $12.50.

REVIEW OF CHILD DEVELOPMENT RESEARCH, vol. 2. Edited by Lois Wladis Hoffman and Martin L. Hoffman. Prepared under auspices of the Society for Research in Child Development. Russell Sage Foundation, New York. 1966. 598 pp. $8.

MONTESSORI FOR THE DISADVANTAGED: an application of Montessori educational principles to the war on poverty. Edited by R. C. Orem. G. P. Putnam's Sons, New York. 1967. 191 pp. $4.95.

THE UNWED MOTHER. Edited by Robert W. Roberts. Harper & Row, New York. 1966. 270 pp. $3.25.

BOOK NOTES

CHILDREN: development and relationships. Mollie S. Smart and Russell C. Smart. The Macmillan Co., New York. 1967. 582 pp. $7.95.

A textbook for students preparing for professional work with children, this book, according to its authors, integrates the teachings of Erik Erikson on the stages of personality development and of Jean Piaget on the stages of intellectual development. The first chapter gives a general view of growth and development; the others center on the prenatal period and infancy, the preschool years, the elementary school years, and adolescence.

POVERTY IN CANADA AND THE UNITED STATES: overview and annotated bibliography. Benjamin Schlesinger. University of Toronto, Press, Toronto, Ontario, Canada. 1966. 211 pp. $5.

By way of introduction to this book, four social work educators—one Canadian and three Americans—present a "critical overview" of the efforts of their nations to end poverty. The annotated bibliography of nearly 600 articles, books, summaries, and monographs describing these efforts that follows is divided under such topics as family life, economics, education, social services, social work, health, housing, and law.

INTERNATIONAL BIBLIOGRAPHY OF RESEARCH IN MARRIAGE AND THE FAMILY, 1900–64. Joan Aldous and Reuben Hill. University of Minnesota Press, Minneapolis, for the Minnesota Family Study Center and the Institute of Life Insurance. 1966. 508 pp. $15.

This volume is the product of the first phase of the Minnesota Inventory of Published Research on Marriage and Family Behavior—"identification of the topics which have been empirically investigated by marriage and family researchers." It lists 12,850 research reports and theoretical essays published from 1900 to (November) 1964 in the United States and abroad in which marriage or the family figured in some way. Prepared with the use of a computer, the volume has five sections: a keyword-in-context (KWIC) index; a subject index; a complete reference list; an authors list; and a periodicals list.

THE DEVELOPMENT OF THE INFANT AND YOUNG CHILD: normal and abnormal. R. S. Illingworth. The Williams & Wilkins Co., Baltimore, Md. 1966. 378 pp. $10.

The third edition of a work first published in 1960, this book describes the mental development of the infant and preschool child from the point of view of everyday pediatric practice.

The author has enlarged the chapters on prenatal and environmental factors to include recent information and has added new chapters on reflexes and reactions of the newborn child, the assessment of maturity, and the assessment for adoption.

ROOM TO GROW: a study of parent-child relationships. Carroll Davis. University of Toronto Press, Toronto, Ontario, Canada. 1966. 214 pp. $6.

Illustrating her points with the "emancipation profiles" of seven children she followed in a longitudinal child development study from the ages of 5 to 20, the author presents a theory about the process in which a child grows from dependency into a self-directed person who is "emancipated" from his parents' direction. She points out that a child seems to become free of his parents by taking "portions of his life into his own hands" as he gains confidence and competence, and that the attitude of the parents toward the process is a force greatly affecting the child's progress and one around which other influences seem to cluster.

Individuality and emancipation are inseparable, as they are both derived from the quality of the parent-child relationship, the author contends. This relationship is constantly changing, and its balance and freedom determine the degree of reciprocal trust between child and parent, she adds.

EARLY CHILDHOOD DISTURBANCES, THE INFANTILE NEUROSIS, AND THE ADULTHOOD DISTURBANCES: problems of a developmental psychoanalytic psychology. The Psychoanalytic Study of the Child Monograph No. 2. Humberto Nagera, M.D. International Universities Press, New York. 1966. 95 pp. $3.

The author of this monograph approaches the question of childhood disturbances from a developmental point of view. After expressing his dissatisfaction with the content of today's thinking on diagnosis, he maintains that analysts cannot continue to call all childhood disorders "infantile neurosis" or to look for solutions in "any one phase of development." He also rejects the idea that "faulty object relationships" and "faulty ego development" are the only sources of disorder.

He reports that his method of analyzing childhood disorder is to give due attention to the developmental processes in all aspects of the personality (drives, ego, superego, and object relationship) "to enable the clinician to test pathology against the right developmental background and to take into account the ideal picture of normalcy."

ROLE PLAYING FOR SOCIAL VALUES: decision-making in the social studies. Fannie R. Shaftel. Stories by George Shaftel. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1967. 431 pp. $5.75.

As defined in this textbook for the classroom teacher, role playing serves two major functions in the classroom. It can help the teacher in educating children for citizenship and in conducting group counseling in her class. The authors have divided the book between theory and methodology and materials (problem stories that present situations for children to work out in class concerning individual integrity, group responsibility, self-acceptance, and managing personal feelings).

observations from a visit abroad . . .

CHILD CARE IN OTHER COUNTRIES

MARTIN GULA

Specialist on Group Care, Children's Bureau

Political commentators have noted in recent years a growing universality in the social and economic conditions influencing families and children in economically developed countries, despite their political structure. But, is there universality in the kinds of social services provided in these countries to assist families and children who are handicapped by these conditions?

I wondered about this during a 3-week visit recently to the British, Danish, and Israeli parliamentary democracies and the Polish and Yugoslav socialist republics. Three weeks is too short a period for profound observations. However, my impression is that where a child lives makes some difference in the services his country develops because of diversity in political philosophy, tradition, and culture; but also that these differences are beginning to be less apparent as nations are faced with common problems.

The most highly populated country I visited was England, which has about 15 million children under 18 years of age. The smallest was Israel, which has less than a million children. But social workers in all five countries reported the same conditions affecting families and children—increasing urbanization; rising living costs; inadequate housing; employment of mothers; shortage of day-care resources; need for new patterns of social work leadership; and inadequate delivery of welfare services.

These conditions as they exist in many parts of the world have been reported on previously in CHILDREN.[1,2] Therefore, I will confine my comments to resources for day care and foster care and social work leadership as reported to me by government officials and social work leaders in these particular countries.

Day care

Various types of day-care arrangements are available in each of these countries, but nowhere in sufficient quantity to meet the need. In Denmark, for example, an infant or toddler may accompany his employed mother to the establishment where she works; a day nursery is provided within the establishment; the mother nurses and feeds the child there; she may also be called upon to substitute for an absent or sick member of the nursery staff; and she picks up her child immediately at the end of the workday. Danish employers like this plan because it reduces employee turnover, fatigue, and absences.

Other mothers use a community day nursery or day-care center. In all types of centers, the operator is required by Danish law to have 2 years of full-time training, which they usually get at government expense. The training includes classroom and supervised practice instruction. However, with a population of only 5 million people, Denmark still needs day-care facilities to accommodate about 30,000 more children.

In Warsaw, the toddler of the employed mother in many instances can remain home because his "babcha" (grandmother) lives with him and his parents. But the proportion of grandparents living with married children or sons-in-law is decreasing as the housing shortage eases. Grandparents are beginning to find jobs or they become eligible for retirement income and find it possible to live alone. Thus, more demand is made by mothers for day nurseries, baby homes, nursery schools, and 5-day boarding "crèches." Poland doubled the number of its crèches and nursery schools during the 1950's to serve over 350,000 children. The number is steadily increasing.

In Israel, the toddler's mother encounters more difficulty in finding day-care resources. Unless she lives in a kibbutz (only 5 percent of the population do), she will have to seek out a relative or neighbor to care for her child or a commercial nursery or a voluntary organizational day-care center, just as a mother in the United States does.

If the mother lives in a kibbutz, her toddler lives in a "children's house" with four or five other toddlers during the day. He visits with his mother for several hours in the early evening and returns to sleep in the children's house at night. But these traditional kibbutzim child-rearing practices are beginning to change. Young kibbutzim couples are pressing to be allowed to keep their young children at home with them overnight and to use the children's house for day care only.

In most of these countries, many day-care facilities rely on untrained persons to care for the children. But in each country, social work leaders, aware that the early years of childhood are the formative years, are working to have such facilities improved or replaced by centers run by trained personnel who can contribute positively to the child's social, emotional, and educational development.

Foster care

As in this country, physical or economic breakdown in families is reported to be decreasing as a major reason for placing children in institutions and foster families. But psychological breakdown in families is increasing in such cities as London, Tel Aviv, and Belgrade with the result that growing numbers of emotionally disturbed and mentally retarded children are in need of care and treatment beyond their family's capacity to provide. The cities are also experiencing an increase in the number of adolescents who need care away from home because of their family's inability to cope with them.

Because most of these children present difficult behavior and complex problems, the countries are facing a need to improve the quality of traditional foster homes and child-caring institutions at a time when they are find-

ing it difficult to recruit urban foster homes and staff members for the institutions.

England has more children in foster family homes (30,000) than it has in institutions (24,000). Foster family programs are relatively small in the other countries. Poland, for example, has only about 250 foster families, but it has about 360 child-caring institutions caring for more than 42,000 children.

Denmark is increasing the public proportion (99.5 percent) of the financing of its 300 child-caring institutions; developing smaller group homes; and operating a national training program for infants' nurses, day-care and kindergarten staff, leaders for boys' and girls' clubs, and institutional child-care staff.

Denmark's national training program for child-care staff was established in 1958 in a former 90-room royal palace in Jaegerspris. About 75 young men and women are trained there annually for work in public or voluntary institutions. A full-time director and five faculty members, provide the students with 1,500 hours of classroom instruction and supervised practice over a 12-month period. Plans are to develop six more of these "colleges" to train 400 students annually. An advanced training program, also run by the government, is available in Copenhagen. The Children's Department of the British Home Office operates a similar and even larger training program.

In Yugoslavia, several rural villages have been made into "foster family villages." The unsophisticated nature of the peasant families, however, precludes their being used for the care of children with complex developmental problems.

In Bristol, England, public child welfare officers are experimenting with a ring of small, public agency-owned group homes near the perimeter of the city. These homes are used for many purposes, such as emergency shelter and foster care of adolescent homeless children, family groups of children, and children too disturbed for traditional foster family homes.

Professional leadership

Denmark, Poland, and Yugoslavia have relied heavily on volunteers, citizens committees, and factory welfare committees to respond to the needs of the family with a child in distress. England and Israel have trained social workers in undergraduate college programs.

But none of these countries has developed graduate professional schools of social work similar to professional social work schools in the United States. However, in England, Denmark, Poland, and Israel perhaps more creative use is made than in this country of undergraduate-trained workers and citizen volunteers in responding quickly to families in distress.

In all five countries the ministries of welfare and the social work leaders are pressing for new patterns of professional leadership, but in each the patterns are developing in different ways. Denmark, for example, has a central children's bureau and about 50 citizen volunteer district children's committees to serve a total of about 750,000 children and youth under 21 years of age. Recently, its parliament passed legislation to train and introduce "family counselors" in urban areas especially for disturbed and delinquent children and their parents.

In Warsaw and Poznan, universities are developing undergraduate training schools for "social assistants" who will help coordinate the efforts of the 60,000 volunteers in Poland who work with families and children in the 400 "poviats" (counties).

In Israel, institutions for dependent and delinquent children, as well as a new day-care center for retarded children, are experimenting with group-work and casework services for children and parents.

In all five countries, national ministries and voluntary child welfare organizations express deep interest in and special concern for the welfare of children without parents. The question they all face is how to develop community services and resources to strengthen the family and improve foster family and residential group care for children who must live away from home and in doing so to use all local health, education, and mental health resources.

[1] Close, Kathryn: Social strategists for urban development. *Children*, November–December 1966.

[2] Oettinger, Katherine B.: Youth and youth services in England. *Children*, March–April 1967.

Guides and Reports

CHILDREN AND YOUTH AT MID-DECADE: the report of the Mid-Decade Conference on Children and Youth, Washington, D.C., April 12–15, 1966. National Committee for Children and Youth, 1145 19th Street NW., Washington, D.C. 20036. 1967. 217 pp. $2.

Includes the texts of addresses and reports made at the conference and summaries of the work groups.

SUCCESSFUL FOSTER HOMES: an exploratory study of their characteristics. Patricia W. Cautley, Martha Jean Aldridge, and Bernard Finifter. Foster Homes Research Project, Wisconsin Department of Public Welfare, Madison, Wis. 53702. June 1966. 232 pp. A limited number free on request from the Department.

Reports in detail on a study whose findings were summarized in the November–December 1966 issue of CHILDREN, p. 247.

UNMARRIED PARENTHOOD: clues to agency and community action. National Council on Illegitimacy, 44 East 23d Street, New York, N.Y. 10010. 1967. 90 pp. $2.50.

The nine papers included discuss aspects of parenthood out of wedlock in the AFDC program, in urban ghettos, and in rural areas; problems in and approaches to the provision of services; the legal rights of unwed parents; and sex education as a way to prevention.

ENQUIRY INTO SUDDEN DEATH IN INFANCY. Ministry of Health. Her Majesty's Stationery Office, London. Available from British Information Service, 845 Third Avenue, New York, N.Y. 10022. Reports on Public Health and Medical Subjects No. 113. 1966. 52 pp. 90 cents.

Reports on the findings of studies of sudden and unexpected deaths of infants in Cambridgeshire and in 12 boroughs of London, conducted mainly between January 1958 and October 1964 by a steering committee appointed by the Ministry of Health.

HERE and THERE

Nursing education

The National League for Nursing and the American Nurses' Association have set up an autonomous commission to study the needs in and objectives of nursing education. Called the National Commission for the Study of Nursing Education, Inc., the 15-man commission represents many fields, including business, health, education, and social sciences. W. Allen Wallis, president of the University of Rochester, will head the 3-year study. Grants from the Avalon Foundation and the W. K. Kellogg Foundation and an anonymous gift are supporting the study.

The objectives of the commission are: to determine what community needs in nursing care and services the profession can reasonably meet; to determine what resources are necessary to provide nursing education and good economical nursing services; to evaluate nursing education and services in terms of the preparation and leadership prerequisite to good nursing care; and to determine ways of making good nursing care available wherever it is needed.

Day care

Some 200 persons who attended a 1-day conference on day care in Washington, D.C., last June, agreed that the need for day-care services for children grows larger every day but that the means of meeting it lags far behind. The conference was called by two Federal agencies—the Women's Bureau of the Department of Labor and the Children's Bureau of the Department of Health, Education, and Welfare—and Directions Seminar, a group representing nine voluntary organizations. In all, 60 organizations and agencies concerned with the welfare of children sent representatives.

Participants pointed out that a great block to providing sufficient day care to meet the needs is the national ambivalence toward the working mother. On the one hand, her services are welcomed where men are not available for jobs; on the other, many people frown on mothers working outside the home.

The participants agreed that the agencies working to make day care for children available wherever it is needed should take their case to the Nation. "We must spell out the cost and say what we want and why," one participant said in summary.

Other participants recommended the establishment of an agency to coordinate the efforts of all agencies working for day care and to publish a news sheet about activities affecting day care. Others recommended the establishment of an organization in every State to work for day-care facilities.

Anti-delinquency

A strong determination in young people to have some say in planning and executing the programs that affect them was expressed during and after a conference on juvenile delinquency held in Washington, D.C., June 1–2, 1967, at the call of the Secretary of Health, Education, and Welfare, John W. Gardner. In addition to 200 professional persons from the fields of juvenile corrections and youth guidance, the conference participants included 45 teenagers and young adults who are serving as "indigenous workers" or otherwise participating in anti-delinquency or anti-poverty programs.

The focus of the conference was on planning and evaluating programs to combat delinquency with special emphasis on the possibilities of building on lessons learned from the projects supported under the expiring (June 30, 1967) Juvenile Delinquency and Youth Offenses Control Act of 1961.

Secretary Gardner pointed out that $47 million had gone into those projects to test new methods of combating delinquency—including work training for jobless young people, the revitalization of neighborhoods, the expansion of legal services to the poor, the establishment of multiservice neighborhood centers, and the effort to involve local people in the planning and executing of community programs. Other speakers identified the major contribution of such projects as their emphasis on preplanning, comprehensiveness, and integration of services and on the participation of the consumers of service. Some, however, criticized the projects for an overemphasis on delinquency prevention to the comparative neglect of rehabilitative efforts, a failure to relate to the existing structure of services in a way that would assure continuance, and a lack of built-in methods for evaluation.

Several of the young participants told of their difficulties in getting adults to listen to their suggestions for improving the conditions that spawn delinquency. For example, one young girl told of a neighborhood youth organization in a Brooklyn neighborhood that has worked for desegregating the extracurricular programs in the local high school, State support to help the children of public welfare clients go to summer camp, group homes for dependent adolescents, a desirable site for a new school—all to no avail: "The only thing we succeeded in changing so far is ourselves."

Other young participants spoke of their efforts to help delinquents or potential delinquents work to meet the needs of their communities. Advised one, "Go back and ask the young people of your community 'what do you want so you can stay out of jail?' . . . Talk to the kids, they have something to give, but they can't give it, if you don't listen."

This sense that the adults are not listening prompted the young participants, under the leadership of those in the Washington community action program, to hold a conference of their own, called A Youth Rap, on the day following the delinquency conference. Their agenda contained three items: youth problems, youth programs, and youth federation. There, however, the dis-

cussion was not so much on problems—"We all know what the problems are"—as on the development of a mechanism for exerting influence on "all the youth work being done in this country." As a first step they decided to work for a national conference of young people, organized by young people themselves "with no strings attached."

Child health

Provisional figures on infant mortality for the 12 months that ended April 30, 1967, show a 5-percent drop from the previous 12-month period—from 24.2 per thousand live births to 23.0 per thousand—according to figures from the National Center for Health Statistics, Public Health Service. This is an even greater decrease than the one shown by provisional rates for the 12-month periods which ended April 30, 1965, and April 30, 1966—24.6 and 24.2 respectively—a drop of 2 percent.

Adoption service

The Indian Adoption Project sponsored by the Bureau of Indian Affairs, U.S. Department of the Interior, and the Child Welfare League of America in cooperation with State and local public and voluntary child welfare services placed 67 Indian children in adoptive homes in 1966, the highest number in any one year since the project began in 1958. As of May 15, the project had placed 325 Indian children in adoptive homes, mostly non-Indian. The children ranged in age at time of placement from birth to 11 years, but nearly half were under a year old. The project at present reports having more prospective adoptive parents than children referred for adoption, although it has found through a survey of 90 registered placement agencies that more than 400 Indian children are in need of adoptive homes.

All the Indian children placed through the project have come from Midwestern or Western States, but more than half of the adoptive homes are in the East.

. . .

The Midwest Adoption Facilitating Service, a regional agency to help local agencies in seven States and a neighboring province of Canada bring children in need of homes and prospective adoptive parents together anywhere in the region, was recently incorporated in Minnesota with headquarters in Minneapolis-St. Paul. More than 90 agencies, both local and statewide, took part in setting up the service. The region includes the States of Illinois, Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin and the province of Manitoba.

The new agency grew out of the work of the Indian Adoption Service conducted by the Child Welfare League of America (CWLA) and the Bureau of Indian Affairs, U.S. Department of the Interior, which places Indian children from one region of the country in homes in another if no homes are available where the children live. The service will also assist in the work of CWLA's national adoption exchange.

The service will not place children itself. Rather, it will work to improve the lines of communication between local agencies and their policies and procedures and to modify State laws that make interstate adoption difficult (only Illinois and Wisconsin now have interstate adoption laws). It will stress service for all children, including those called "hard-to-place." A survey of the States involved indicated that over 2,000 children had been waiting more than 90 days for adoption.

Milt Erickson of the Lutheran Social Services, Sioux Falls, S. Dak., has been elected president of the board for the service. His agency has been particularly active in working for an interstate adoption facilitating agency.

Unmarried mothers

The first regional conference on continuing education for pregnant teenage girls took place in Detroit, Mich., May 4–5, under the auspices of the Office of Education, U.S. Department of Health, Education, and Welfare, and the Detroit public school system. The participants included 175 persons—chiefly educators and staff members of health and welfare agencies from both urban and rural areas in Illinois, Indiana, Michigan, Ohio, and Wisconsin. They focused their attention on the school's role in providing continuing education and supportive services for teenage pregnant girls and unwed mothers, the kinds of interdisciplinary and interagency comprehensive programs now available to them in some places, and resources for financing program development and expansion.

Speakers described programs in Chicago, Detroit, Los Angeles, and Washington, D.C., stressing the importance of coordination of health, education, and social services and of interprofessional efforts on behalf of the girls. They also discussed ways of dealing with negative attitudes in the community and pointed to the importance of involving representatives of all segments of the community in getting a program underway. In a discussion of the educational content of a program, courses in nutrition, baby care, and physical and emotional development were recommended to be added to the regular school curriculum.

Education

About 3,000 children who enrolled in kindergartens and first grades this fall are receiving special educational attention through Follow Through projects in 30 school districts in 25 States and the Commonwealth of Puerto Rico. They are the participants in the pilot phase of a new Federal program to help schools sustain the intellectual, social, and physical gains made by disadvantaged children in preschool educational programs, especially the preschool centers established under Project Head Start. The new program is administered by the Office of Education with funds provided by the Office of Economic Opportunity.

Participating schools are using new teaching methods and the services of teaching specialists, teacher aides, psychologists, social workers, and medical specialists to meet whatever needs the children have that affect their ability to get ahead in school. In addition, parents are taking part in Follow Through—as aides or volunteer helpers in the classroom and on field trips and as members of policy advisory committees. Most of the children involved are attending regular classes where they receive special attention. In addition, many schools are providing the children with help in extended day classes—that is, after regular schoolhours.

According to present plans, Follow Through assistance will eventually be provided to children through the third grade. As experiments, the programs are open to visitors from other school districts, and evaluation reports on them will be sent to other school districts.

The States with Follow Through pro-

FOR CHILDREN OF THE AMERICAS

When the Council of the Organization of American States (OAS) on June 7, 1967, gave final approval to the budget of the Pan American Union (PAU) and certain specialized organizations for the fiscal year ending June 30, 1968, the largest percentage increase authorized for any agency—14.04 percent—was for the Inter-American Children's Institute (IACI) which is celebrating its 40th anniversary this year. (The increase for PAU as a whole was 3.62 percent.) The IACI budget for the 1968 fiscal year is $139,939, as compared with $122,706 for 1967.

Recent IACI activities have included three regional seminars to develop standards for family and child welfare in integrated programs of national development; seminars on vocational training of adolescents in Brazil and Venezuela; a nutrition course for training workers to combat malnutrition in Haiti; courses on legislation pertaining to minors in Bolivia and Paraguay; an advisory service to the national councils for minors in Argentina and Peru; a training course for social workers specializing in child and family welfare, in cooperation with the University of Costa Rica; cooperation with the International Children's Center of Paris in a course for schoolteachers on understanding child behavior, given in Brazil; seminars in Bolivia and the Dominican Republic for officials of civil registry offices, with the objective of improving birth registration and other statistics on children.

IACI has just created a section on mental retardation and will soon hold a seminar on the subject. Another IACI innovation this year will be a series of courses for juvenile court judges and auxiliary court personnel, the first of the kind in Latin America. IACI is also carrying responsibility for the preparation of working documents for the XIII Pan American Child Congress to be held in Quito, Ecuador, early in 1968. The basic theme of the Congress will be "Population Growth and Its Incidence on Planning for Children and Youth."

The input into IACI activities from cooperating organizations far exceeds IACI's budget. UNICEF contributes fellowships for some of the seminars and training courses; WHO, PAHO, FAO, and the Unitarian-Universalist Service Committee supply experts and funds for nutrition courses and seminars; UNESCO helps with vocational training activities. The services of a small technical staff at IACI's headquarters in Montevideo are supplemented as needed by contracts with experts, thus utilizing and making better known the technical resources already in the American Republics.

—Elisabeth Shirley Enochs

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grams are California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New York, North Carolina, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, and Wisconsin.

Mental retardation

Students in schools of social work had more opportunity in academic year 1965–66 than ever before to obtain experience in working with mentally retarded children, the American Association on Mental Deficiency found in a survey of mental retardation as a focus in social work education. From a questionnaire sent to the 67 member schools of the Council on Social Work Education, the association received 55 replies, only 16 of which indicated that the school had no students placed in mental retardation programs. The other 39 reported 336 full-time students (or 5.6 percent of their total enrollment) in field units or individual placements in mental retardation programs during academic year 1965–66. Most of these placements had been set up since 1963.

The survey showed that 32 schools had 57 field units for 264 students using the three basic social work methods; about half were in residential institutions. Seventy-two students were in individual placements—the majority doing casework—in 10 mental retardation programs in 40 agencies, most of them residential institutions and developmental and evaluation clinics. Both types of placements received some Federal support, either from the Vocational Rehabilitation Administration, or the Public Health Service, or the Children's Bureau.

The survey also found that 37 schools had faculty positions for field instructors in mental retardation units; 27 schools had full-time faculty members and 10 had part-time faculty members. Relevant mental retardation content was included in the basic curriculum sequences and research. The content was presented through case teaching methods, formal lectures, assigned readings, audiovisual aids, field observations, and assigned cases in field placements. In 1965–66, 10 schools also conducted short-term training programs in mental retardation such as workshops, seminars, and institutes for faculty members and practitioners.

The schools indicated that they needed teaching material concerning mental retardation, that they had had difficulty recruiting field instructors with experience in social work with the retarded, and that students had difficulty integrating what they were learning in the field with what they were learning in the classroom.

. . .

Several State agencies in Iowa and many private social agencies in the State are developing a short-term training project for the foster parents of mentally retarded children. Twelve institutes will be held between October and December of this year. The State agencies involved include the State University of Iowa School of Social Work; the State Department of Social Welfare; the two State institutions for the mentally retarded; the Iowa Welfare Association; and the State mental re-

tardation planning agency, Progressive Action for the Retarded.

. . .

To expand and improve foster family care for mentally retarded children, the Minneapolis Association for Retarded Children is recommending that—

- Licensing standards be developed specifically for foster family homes for retarded children.
- The fee structure for such homes be modified.
- Agency-owned foster homes, run by agency personnel, be established.
- Training programs be conducted for the foster parents of mentally retarded children.
- Staffing requirements be established for foster boarding homes that care for more than five children.

These and other recommendations are the results of an inquiry the association made into the use of foster boarding homes for mentally retarded children by the Hennepin County Welfare Department. The association found that the quality of the program was impaired by the manipulation by placement agencies of standards developed for the foster care of normal children; the shortage of available foster homes for mentally retarded children; and the lack of other types of residential facilities for mentally retarded children in the county.

As a result of this study, the Minneapolis Department of Public Welfare is now developing new standards and guidelines for foster group homes caring for mentally retarded as well as "normal" children.

The report of the study, "Foster Boarding Care for Mentally Retarded Children," by Sheldon R. Schneider, is available from the association (2401 West 66th Street, Minneapolis, Minn. 55423).

. . .

Mentally retarded children placed in foster families made greater improvements over a 3-year period in all aspects of development, including intelligence, than did children with the same degree of retardation who were placed in an institution, according to the findings of a study recently completed in Kentucky. Conducted by the Kentucky Department of Child Welfare, with the cooperation of the Kentucky Department of Mental Health and support from the Children's Bureau, the study focused on 30 children placed in foster family homes and 29 placed in a State institution for the retarded.

The two groups were matched at the beginning of the study according to age, sex, IQ, and previous experience in foster care. Both groups of children received training through special education programs during the study period, and both groups made progress in social behavior. Whether or not the children had been diagnosed as functionally or organically retarded bore no significant relation to their degree of intellectual improvement.

As a byproduct, the study demonstrated that foster family homes can be found and sustained for mentally retarded children. In selecting foster parents, the project relied heavily on the social workers' evaluation rather than outside references; foster parents were not excluded because of negative characteristics if they showed counterbalancing kinds of strength; the reports of family physicians on the health instead of the findings of public health clinics, as is usual.

The agency provided the foster parents with casework counseling, individually and in groups, on a more highly concentrated basis than is usually provided foster parents.

The project was directed by Marjorie Wilson. Robert Fishman was its research director.

Foster care

The Iowa Children's Home Society, a voluntary agency in Des Moines, has developed two programs involving foster parents that, it reports, have greatly helped the agency in its work. One offers group consultation to foster parents in place of individual casework; the other is a public relations program through which foster parents interpret the agency's work to civil and religious groups.

Under the first program, about 130 foster mothers and fathers are now assigned to nine consultation groups, which meet at hours convenient to them. During the meetings, conducted by an agency caseworker, the parents discuss their problems as foster parents and their relations with the agency.

The agency also reports that both parents and staff members have accepted the group discussion as a substitute for individual casework and that it has made the method part of its continuing supportive services for foster parents.

Under the second program, now in its fourth year, a panel of four foster mothers, each caring for a different kind of child, give brief talks about the problems and rewards of giving foster care and how they and the agency work together. If the program is at night, a foster father may join the panel to explain his duties as a foster father. The community relations worker from the agency talks briefly about the agency, the supervisor of foster care moderates the panel, and together with the panel members they answer questions from the floor.

. . .

Foster grandparent programs to provide employment for the elderly and the warmth of individual grandparent relationships to neglected, dependent, disturbed, or mentally retarded children have demonstrated great value both for the elderly persons and the children involved, according to a study recently reported by Greenleigh Associates, a nonprofit research organization. The study was made for the Office of Economic Opportunity (OEO) of 10 of the 22 foster grandparent programs being supported by OEO in 1966.

The organization found, on the basis of "professional observations," that 70 percent of the children served showed some physical, social, and emotional improvement and that this improvement in more than 90 percent of the cases could be attributed in part to foster grandparent care. It also found that weaknesses in administration and operation were often offset by the strength of the goals and the design of the programs; and that the programs relied on leadership from OEO and the Administration on Aging, U.S. Department of Health, Education, and Welfare, because they received little local support.

The study was conducted through interviews with members of the sponsoring and host agencies (hospitals and institutions for neglected, dependent, disturbed, or mentally retarded children), site observations, and studies of primary resource material. All of the foster grandparents had been in the program for at least 2 months; all of the children, for at least 2 weeks. Most of the children were about 5 or 6 years old,

though their ages ranged from under 1 to over 13.

Of the 396 children involved, 70 percent were reported to have improved in their behavior or in their health; 56 percent showed improvement in their relationships with others; 52 percent showed improved emotional adjustment; 38 percent showed improvement in physical health and in sleeping and eating habits, and 38 percent, in physical mobility, motor skills, and self-care. The extent of these improvements was found to be similar in all types of institutions, except in an institution for emotionally disturbed teenage children, where only 19 percent of the children with foster grandparents seemed to show improvements.

Most of the 269 foster grandparents in the programs studied were women, though both men and women had been sought in recruitment efforts. Most of the elderly persons learned about the program through the newspapers, friends, or social agencies; only a very few, through employment agencies.

The programs studied were in Atlanta, Ga., Denver, Colo., Fort Wayne, Ind., Madison, Wis., Morganton, N.C., Nashville, Tenn., New York, N.Y., Philadelphia, Pa., St. Cloud, Minn., and San Francisco, Calif.

The study organization recommends that the foster grandparents program be greatly expanded to reach more communities and, through the sponsors, as wide a variety of agencies as possible. Among other recommendations, it also urges that the one-to-one relationship between child and foster grandparent be kept wherever possible and that greater efforts be made to reach potential foster grandparents in low socioeconomic neighborhoods.

(For a description of a foster grandparent program, see CHILDREN March–April 1967, pp. 47–52.)

in the journals

School nursing services

The efforts of parents in low socioeconomic areas of Oakland, Calif., to make and keep their children healthy increased appreciably after school nurses in a special demonstration project worked more closely with them than is usual, according to Doris S. Bryan and Thelma S. Cook in the July 1967 issue of the *American Journal of Public Health*. ("Redirection of School Nursing Services in Culturally Deprived Neighborhoods.") The school system found that assigning trained clerical assistants to nurses to handle routine duties such as running the office and keeping records on pupils and assisting in visual screening gave the nurses more time to work with parents, particularly those whose children had special health problems, the authors report. The three nurses' assistants employed for the project received 20 hours of formal inservice training in addition to continuing supervision from the nurses.

The parents of children in three kindergartens received special counseling and parent education services from the nurses; those of children in three others, who did not receive special service, were studied for comparison. Contacts with parents were made in the home and in the school.

The authors report that the school system found that an urgent need exists to identify the ways in which the service should be redirected to meet the needs and problems of pupils and parents, the goals the nursing service can attain, and the knowledge and skill needed by nurses in such a program. "Nurses may need . . . to research nursing problems. . . ."; and "Redirection may be toward the development of a more highly *skilled* school nurse practitioner," the authors maintain. The program was supported in part by a research grant from the Children's Bureau.

Grownup child

New Generation is the new name of the *American Child*, bulletin of the National Committee on Employment of Youth, itself a transformation of the National Child Labor Committee. The publication originally appeared over 50 years ago as the *Child Labor Bulletin*.

In its first issue as the *New Generation* (summer 1967), the bulletin focuses attention on possible strategy for sustaining the war on poverty by presenting a symposium of diverse views on what should be done about the structure and programs of the Office of Economic Opportunity (OEO). The contributors: Richard W. Boone, executive director, Citizens' Crusade Against Poverty; Congressman Charles E. Goodell of New York; Hyman Bookbinder, assistant director, OEO; Kenneth E. Marshall, vice president, Metropolitan Applied Research Center, Inc.; S. M. Miller, program adviser, Ford Foundation.

Emergency parents

An around-the-clock emergency parent service has ended the need for suddenly taking children out of their homes for the Children's Aid and Society for the Prevention of Cruelty to Children in Erie County (Buffalo), N.Y., the agency's executive director Norman W. Paget, reports in the July 1967 issue of *Child Welfare*. ("Emergency Parent—A Protective Service to Children in Crisis.") In the first 11 months of the program, the agency sent emergency parents into 32 homes where 128 children had been left alone, he says. In every case, the emergency parents, sometimes in relays, were able to care for the children until their parents or guardians assumed their parental responsibilities or until the agency could find the right foster homes, he points out.

The agency recruits both men and women and sometimes couples as emer-

gency parents, the author reports. They are on call except while at work for a week at a time and receive a small fee while on call and pay at an hourly rate while in actual service. Each is carefully instructed regarding the duties of emergency parents. This instruction includes describing the limits of these duties—the emergency parent, for instance, does not deal with the parents in any way.

An emergency parent brings a kit of such items as cookware, light bulbs, and insect spray with him when he goes into a home, and, as instructed, he uses an agency staff car equipped with a radio-telephone in case the home has no telephone, as many do not. He also carries an aerosol spray for protection, if needed. However, though parents are often hostile toward emergency parents when they return home, none has ever been violent, the author reports.

The author points out that while the agency has a homemaker service to serve families in crises such as a mother's illness homemakers are not expected to go into homes in which there is a potentially dangerous situation or in which there is no responsible adult with whom to plan.

Birth weight and blindness

Perinatal factors and low birth weight seem to be associated with blindness in the newborn infants, according to an article in the June 1967 issue of *Public Health Reports* reporting on a study of 553 blind children in New York State. ("Association of Perinatal Factors With Blindness in Children," by Irving D. Goldberg, Hyman Goldstein, Dana Quade, and Eugene Rogot.)

Of the children studied, a greater proportion than in the general population weighed less than normal at birth—indeed, low birth weight characterized them—and more were of twin birth, the investigators found. They also found a greater proportion than usual of mothers who were at the extremes of the maternal age span (under 20 or over 35), had had complications of pregnancy or labor, were primiparas, or had had stillbirths.

The authors report that the most common type of blindness in the children was from congenital cataracts.

readers' exchange

HAGGERTY: *Comprehensive care*

I want to commend the emphasis in Dr. Haggerty's article on the need to incorporate the concept of comprehensive care into medical training. ["Pediatric Training and the Manpower Problem," by Robert J. Haggerty, M.D., CHILDREN, May–June 1967.]

Each person's potential for physical, cognitive, and sociobehavioral health and competence must be nurtured and protected during the formative years in utero and childhood if the citizens of our Nation are ever to attain high-level wellness of body and mind. That we are far from achieving this goal is obvious from the high incidence of physical, intellectual, and behavioral disabilities among the youth of our Nation.

The causes and consequences of many of these disabilities lie as much in the social and behavioral disabilities as in the biologic and physical. Yet, we continue to educate medical students, house officers, and residents as though most of the important maladies of mankind could be cured or prevented by biophysical means alone. This is not surprising, for it takes a great deal of effort and skill to alter deeply rooted traditions in fields as firmly established as medical education.

It may be advantageous and, perhaps, essential to incorporate the elements of comprehensive health care into the medical curriculum at its outset. Otherwise, students may continue to be so strongly conditioned to think only in biophysical, curative terms that by the time they come to the final stages of residency training they will have little awareness of the significance of social phenomena in medicine and little incentive to invest in a career of comprehensive health care.

This relatively undeveloped segment of medicine is loaded with fascinating and challenging opportunities for imaginative research. The possible topics range from developing methods for the systematic identification and measurement of social and behavioral factors of critical importance in human development, health, and disease to identification of the important variables in the politics, staffing, financing, delivery, and evaluation of comprehensive health care for segments of the population.

Some medical students might be attracted to university-based careers as investigators and teachers in this field. More important perhaps, many others might be attracted to careers as physicians whose knowledge and skill in the field of comprehensive health care is at least equal to the skill of physicians who are subspecialists in various sharply delimited areas of medicine. Thus physicians trained to provide comprehensive care could, with the support of allied health workers and modern technological devices, take over where the general practitioners of the past have left off, and raise the standards of medical care in our country to new heights.

Thanks to the Children's Bureau and the National Institute of Child Health and Human Development, these exciting possibilities are already being converted into reality, thus providing pediatrics with new opportunities to lead the way in solving some of the Nation's pressing contemporary health problems as it has in the past in controlling the infectious, nutritional, and related diseases that used to kill or maim so many children.

Nathan B. Talbot, M.D.
Charles Wilder Professor of Pediatrics
Harvard Medical School

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NATIONAL CONFERENCE ON EDUCATION OF THE DISADVANTAGED: report of a national conference held in Washington, D.C., July 18–20, 1966. Department of Health, Education, and Welfare, Office of Education. OE–37004. 1966. 86 pp. Single copies free from the Division of Compensatory Education.

Contains summaries of the conference's panel discussions and of special programs, texts of major addresses, and comments of panelists.

CHILDREN OF DEPRIVATION: changing the course of familial retardation. Robert B. Kugel, M.D., and Mabel H. Parsons. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 440. 1967. 86 pp. 35 cents.

Reports on a 5-year project to: (1) record the growth and development of a group of preschool children with "familial mental retardation"; and (2) attempt to alter the unfavorable course of their development by enriching aspects of their individual lives, homes, and schools. Also includes a discussion of the nature of familial mental retardation and an examination of the literature.

RECOMMENDED GUIDELINES FOR PKU PROGRAMS. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 14 pp. Single copies free from the Bureau.

Brings together into one booklet, with some revisions based on recent experience, two guidelines previously issued separately: one for developing phenylketonuria (PKU) screening programs and the other for developing comprehensive followup services for children with PKU and hyperphenylalaninemia.

PHENYLKETONURIA: a comprehensive bibliography—1964. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 430. 1966. 86 pp. 35 cents.

Lists 817 references on phenylketonuria under eight heads: general; biochemistry; genetics; case histories; mental retardation; physical pathology; dietary treatment; and surveys and screening. Includes foreign references.

MENTAL RETARDATION ACTIVITIES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, JANUARY 1967. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Individual and Family Services, Secretary's Committee on Mental Retardation. 1967. 105 pp. 55 cents.

The latest of a yearly series of reports on mental retardation activities of the Department.

STATE LAWS PERTAINING TO PHENYLKETONURIA AS OF NOVEMBER 1966. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1967. 43 pp. Single copies free from the Bureau.

Contains the texts of 37 State laws relating to the testing of infants for phenylketonuria and, in some instances, other inborn metabolic disorders that may cause mental retardation.

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